

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

15702

CERTIFICATE OF DEATH

15704

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD de Grace c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural 07-2)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		d. STREET ADDRESS RD 1	
3. NAME OF DECEASED (Type or print) John Wayne Abrams		First John	Middle Wayne
4. DATE OF DEATH Month Nov. Day 3 Year 1966	5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10-26-66	9. AGE (In years last birthday) yrs. 9	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS. Hours 9 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		11. BIRTHPLACE (County & State, or foreign country) HARFORD, Maryland	
12. CITIZEN OF WHAT COUNTRY? _____		13. FATHER'S NAME Ronald Lee Abrams	
14. MOTHER'S MAIDEN NAME BETTY JOANNE Mc MILLAN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT Alonso Gomez, M.D. Address 419 S. Union Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute fulminant hepatitis 580X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) Cause undetermined. DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 4 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dehydration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 P.m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on Nov. 3 1966 and that death occurred at 2A M. from causes and on the date stated above.			
22a. SIGNATURE Alonso Gomez		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/3/66
22c. PHYSICIAN'S NAME (Type) Alonso Gomez, M.D.		22d. ADDRESS 419 S. Union Ave, HARFORD de Grace	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov 5/66	23c. NAME OF CEMETERY OR CREMATORIAL BAYVIEW Meth. Cem
24. FUNERAL DIRECTOR Hicks Home for Funerals, M.D.		23d. LOCATION (City or Town) BAYVIEW, Cecil, Md. (County) _____ (State) _____	
25a. ADDRESS Rapley E. Hicks, FIKTON		25b. REC'D BY REGISTRAR NOV 18 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

15204

15205

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15703

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15705

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Calvary Road	
3. NAME OF DECEASED (Type or print) Raby James Bratton		First Raby	Middle James
4. DATE OF DEATH November 4, 1966	Month November	Day 4	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH April 20, 1913
9. AGE (In years last birthday) 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) Fries, Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Bratton	14. MOTHER'S MAIDEN NAME Louivillia V. Martin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 229-18-0132	17. INFORMANT (Wife) Mrs. Elsie S. Bratton	Address RFD#2, Box#112A Bel Air, Md. 21014
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture SKull			INTERVAL BETWEEN ONSET AND DEATH
9121 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost: (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off tractor & it ran over his head	
20c. TIME OF INJURY Month, Day, Year 3/15 p.m. 11-4 1966		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Zion C. L. Smith Bel Air Ha. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C. Palmer</i>	M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 7, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Meth. Cem.
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>		23d. LOCATION (City or Town) Fountain Green, Harf. Co., Md.	(County) (State)
		25a. ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014	25b. REGISTRAR'S SIGNATURE NOV 9 1966 J. Charles Judge
		25c. REC'D BY REGISTRAR NOV 9 1966	25d. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harve de Grace		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Memorial Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Route 2 Box 352	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Lincoln Brumbaugh		First	Middle
4. DATE OF DEATH Nov 8th 1966		Month	Day
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 31 Dec. 1895		9. AGE (In years from last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Clerk (Ret)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. APG	11. BIRTHPLACE (County & State, or foreign country) Penna.
13. FATHER'S NAME David D. Brumbaugh		14. MOTHER'S MAIDEN NAME Katura Ickes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 213-12-0733	17. INFORMANT Address Viola C. Brumbaugh, Street, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Coronary occlusion Chronic myocarditis 2 year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 8 , 1966, to Nov 8 , 1966, that (I) (we) last saw the deceased alive on Nov. 8 , 1966, and that death occurred at 4:30 P.M. from causes and on the date stated above.		22b. DATE SIGNED 11-8-66	
22a. SIGNATURE Dr. Lewis MD		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Havre de Grace, Maryland
22c. PHYSICIAN'S NAME (Type) A. Lewis MD		23d. LOCATION (City or Town) (County) (State) Delta York Penna.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11 Nov. 66	23c. NAME OF CEMETERY OR CREMATORIAL Slate Ridge Cemetery
24. FUNERAL DIRECTOR Charles J. Tarr Funeral Home		25a. ADDRESS Aberdeen, Md.	25b. REC'D BY REGISTRAR DATE NOV 10 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15705

CERTIFICATE OF DEATH

15707

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1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>12 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace, Md</i>		d. STREET ADDRESS <i>106 Wilson St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Alice Pearl Carson</i>		First	Middle
4. DATE OF DEATH <i>November 29 1966</i>		Last	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4/24/1888</i>		9. AGE (In years last birthday) <i>78 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Albemarle Pro. Bus.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Craig</i>		14. MOTHER'S MARRIED NAME <i>Leah Patterson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>820-22-0789</i>	
17. INFORMANT <i>Martin Carson, Havre de Grace, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260x</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>due to</i>			
(b) <i>due to</i>			
(c) <i>due to</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>11-18</i>	(County) <i>11-29</i>
21. I certify that (I) (this hospital) attended the deceased from <i>11-18</i> , 19 <i>66</i> , to <i>11-29</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>11-29</i> 19 <i>66</i> , and that death occurred at <i>11-18</i> M, from causes and on the date stated above.		22b. DATE SIGNED <i>11/29/66</i>	
22a. SIGNATURE <i>Irvin L. Wachsmann M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22b. PHYSICIAN'S NAME (Type) <i>Irvin L. Wachsmann M.D.</i>		22c. ADDRESS <i>Havre de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 2, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Caberry Cemetery</i>		23d. LOCATION (City or Town) <i>Towhessett, Cecil Md</i>	
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Bel Air, Md.</i>		25a. ADDRESS <i>Lee A. Patterson & Son, Bel Air, Md.</i>	
25b. REC'D BY REGISTRAR DATE <i>DEC 1 1966</i>		25c. REGISTRAR'S SIGNATURE <i>for Lee A. Patterson & Son, Bel Air, Md.</i>	

1951

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15706

Item 2 & 3, 8/16/66

CERTIFICATE OF DEATH

15708

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
HARFORD MARYLAND		WASHINGTON, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Grounds		c. LENGTH OF STAY IN 1B 5 months	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIRK ARMY Hospital		d. STREET ADDRESS 625 Silver Bell Drive	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST		4. DATE OF DEATH Month Day Year 11 8 1966	
5. SEX male Caucasian		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1915		9. AGE (In years last birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Warrant Officer		10b. KIND OF BUSINESS OR INDUSTRY ARMY	
11. BIRTHPLACE (County & State, or foreign country) Muskegon, Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph MANLY Cummings		14. MOTHER'S MAIDEN NAME ELIZABETH EBERLY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 26 years		16. SOCIAL SECURITY NO. 029-10-8607 17. INFORMANT Address Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 6 hours 36 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> P.M. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7 November 1966, to 8 November 1966, that (I) (we) last saw the deceased alive on 8 November 1966, and that death occurred at 245 M, from the causes and on the date stated above.		22b. DATE SIGNED 4/8 November 1966	
22a. SIGNATURE Arnold N. Katsoff		22b. ADDRESS KIRK ARMY Hospital	
22c. PHYSICIAN'S NAME (Type) ARNOLD N. KATZOFF		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11/13/1966		23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat. Cem. Arlington, Virginia	
24. FUNERAL DIRECTOR H. C. Coffman, Son, Langhorne, Md.		23d. LOCATION (City, town or county) (State) 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE NOV 15 1966 Charles Judge	

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FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15707

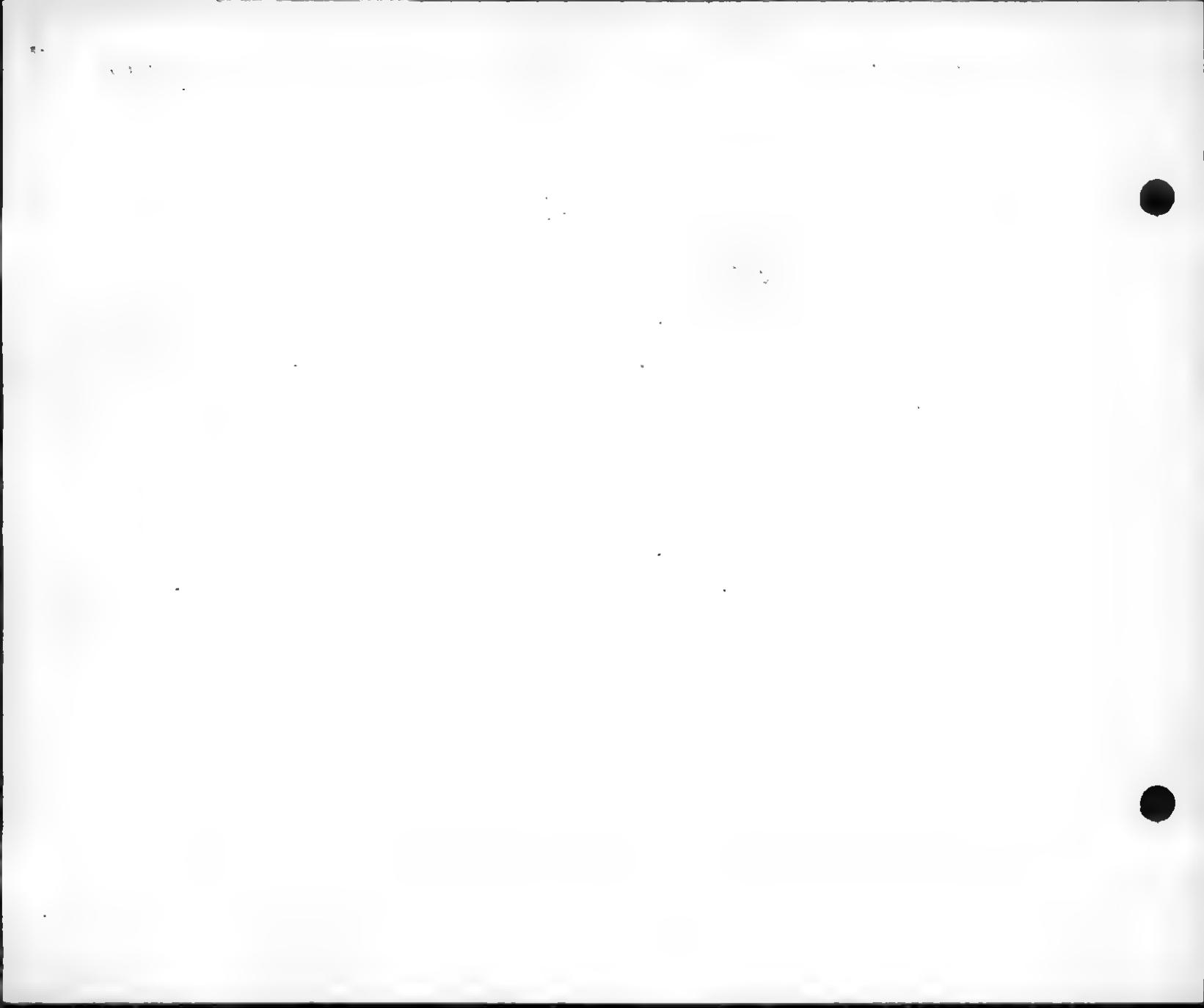
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15709

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1 PLACE OF DEATH a COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Res dence before admission) a STATE Md.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford County, Md.		c LENGTH OF STAY IN lb 1 Day	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e STREET ADDRESS 551 Bourne St	
3 NAME OF DECEASED (Type or print) Harriet Cecelia Dalton		4 DATE OF DEATH Month Day Year November 22, 1966	
5 SEX F		6 COLOR OR RACE W	
7 MARRIED WIDOWED		8 NEVER MARRIED DIVORCED	
9a USUAL OCCUPATION (Give kind of work done Housewife Ret. own Home		9b DATE OF BIRTH 6-4-1908	
10b KIND OF BUSINESS OR INDUSTRY 10c (If most of working life, even if retired)		10d AGE (In years last birthday) 58 yrs	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME Galen Crothers		14 MOTHER'S MAIDEN NAME Annie Tremble	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) No		16 SOCIAL SECURITY NO 220-22-7918	
17 INFORMANT Leslie Cochran Conowingo Md.		18 Address	
19b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4431 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Cerebrovascular Accident	
4431 (b) DUE TO Hyper-tension, arteriosclerotic (c) DUE TO cardio-vascular cerebral Disease			
20c OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19c WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerard E. Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bo'An, Md.	
EXAMINER'S NAME (Type) Gerard E. Palmer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11-26-66	
23c NAME OF CEMETERY OR CREMATORIAL Pleasant Grove		23d LOCATION (City or Town) Peach Bottom	
23e FURNAL DIRECTOR Damon E. H. Hellenfisinger, L.L.C.		(County) PA.	
23f ADDRESS 1000 Main Street, Ligonier, Pa.		25a REC'D BY REGISTRAR NOV 28 1966	
23g DATE 11-23-66		25b REGISTRAR'S SIGNATURE Charles Judge	



1 M
FOR STATE
HEALTH DEPT.

10 INPUT MEDICAL DIRECTOR: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, on any event within 72 hours after death.

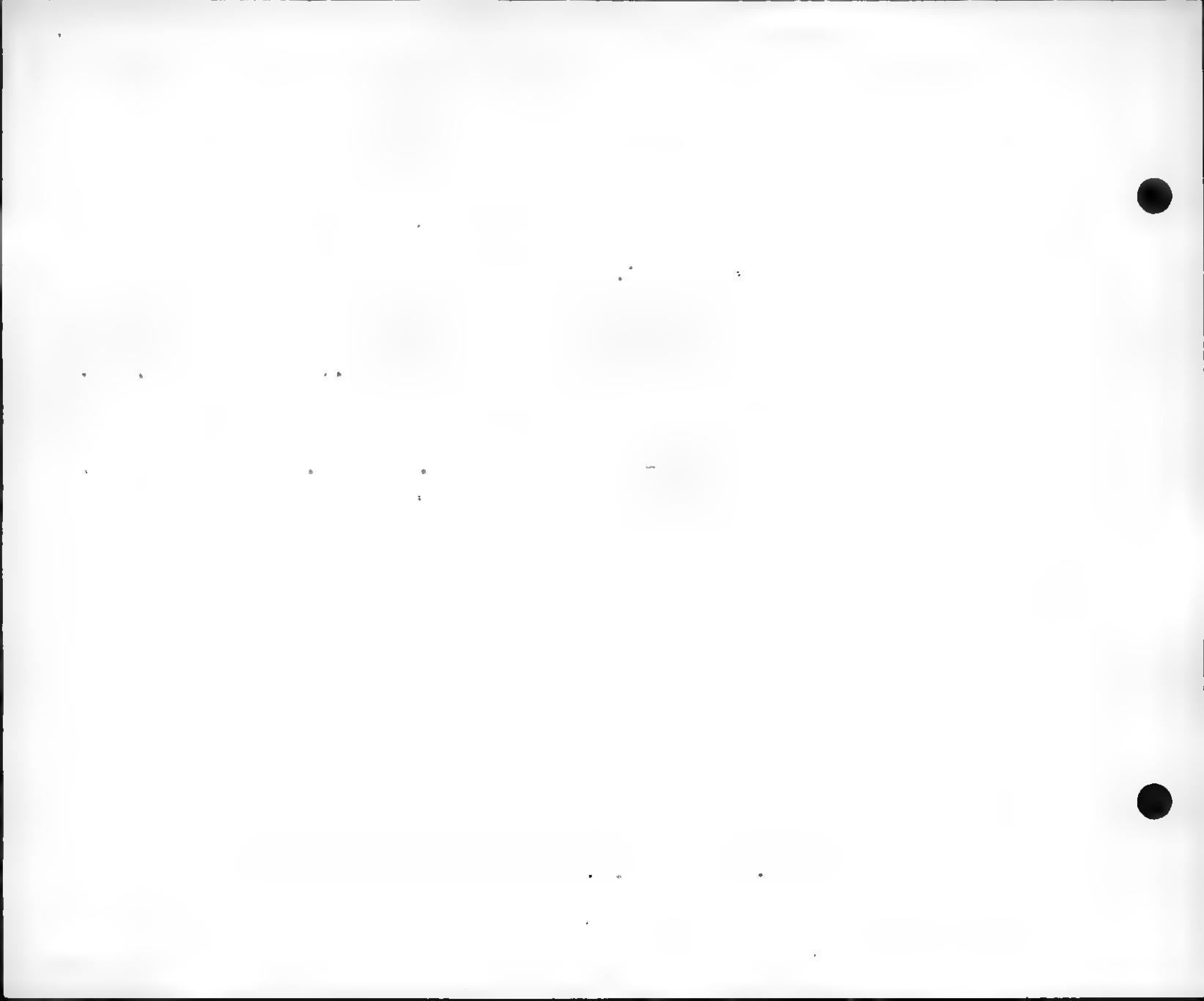
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15710

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hayre de Grace			c. LENGTH OF STAY IN 1b 4 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		
3. NAME OF DECEASED (Type or print) Hattie			First M.	Middle Day	4. DATE OF DEATH 5 Novmeber
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Jan 1887		9. AGE (In years last birthday) 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ticket Seller		10b. KIND OF BUSINESS OR INDUSTRY Theater	11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alex Cullum			14. MOTHER'S MAIDEN NAME Susan Whitcomb		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 215-32-0615		17. INFORMANT John H. Day Jr.	Address Hayre de Grace, Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture L. femur			INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			DUE TO _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) Fell + hit me			
20c. TIME OF INJURY Month, Day, Year hour a.m. Nov 1 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		21f. (City or town) Aberdeen		(County) Harford	
ACTUAL SIGNATURE Gerald C. Palmer		21g. (City or town) Bel Air		(County) Md	
EXAMINER'S NAME (Type) Gerald C. Palmer M.D.		21h. (City or town) Bel Air		(County) Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-8-66		23c. NAME OF CEMETERY OR CREMATORIAL Bakers Cemetery	
24. FUNERAL DIRECTOR Tarrant B. Long, Aberdeen, Maryland		25a. ADDRESS Tarrant Funeral Home, Aberdeen, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15ME (5) 6M 1/66		25c. REC'D BY REGISTRAR NOV 9 1966		25d. DATE NOV 9 1966	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with this form.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File part 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15709

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15711

1. PLACE OF DEATH a. COUNTY		Hagerstown		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore, Md.		Maryland		a. STATE	
c. LENGTH OF STAY IN 1b		1 week		b. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Glenville Road		Hagerstown, Md.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM?		NO		e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH	
3. NAME OF DECEASED (Type or print)		Henry First Longmire Dyer II		Last		Month	
4. DATE OF DEATH		November 21 1966		Day		Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7/26/1949	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
no		Student		Springfield, Mass.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
Harry E. Dyer Jr.		Dora B. Hallion		no		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 11-21-66		20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		20f. (City or town) Dorchester		20g. (County) Md.		20h. (State) 11-21-66	
DUE TO (b)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Robert E. Palmer</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11-21-66	
ACTUAL SIGNATURE <i>Robert E. Palmer</i>		EXAMINER'S NAME (Type) Robert E. Palmer		23a. BURIAL OR CREMATION REMOVAL (Specify) 23b. DATE THEREOF 11/23/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hagerstown Memorial	
24. FUNERAL DIRECTOR <i>Baltimore Funerals Inc.</i>		23d. LOCATION (City, town or county) Alderson, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE NOV 23 1966	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

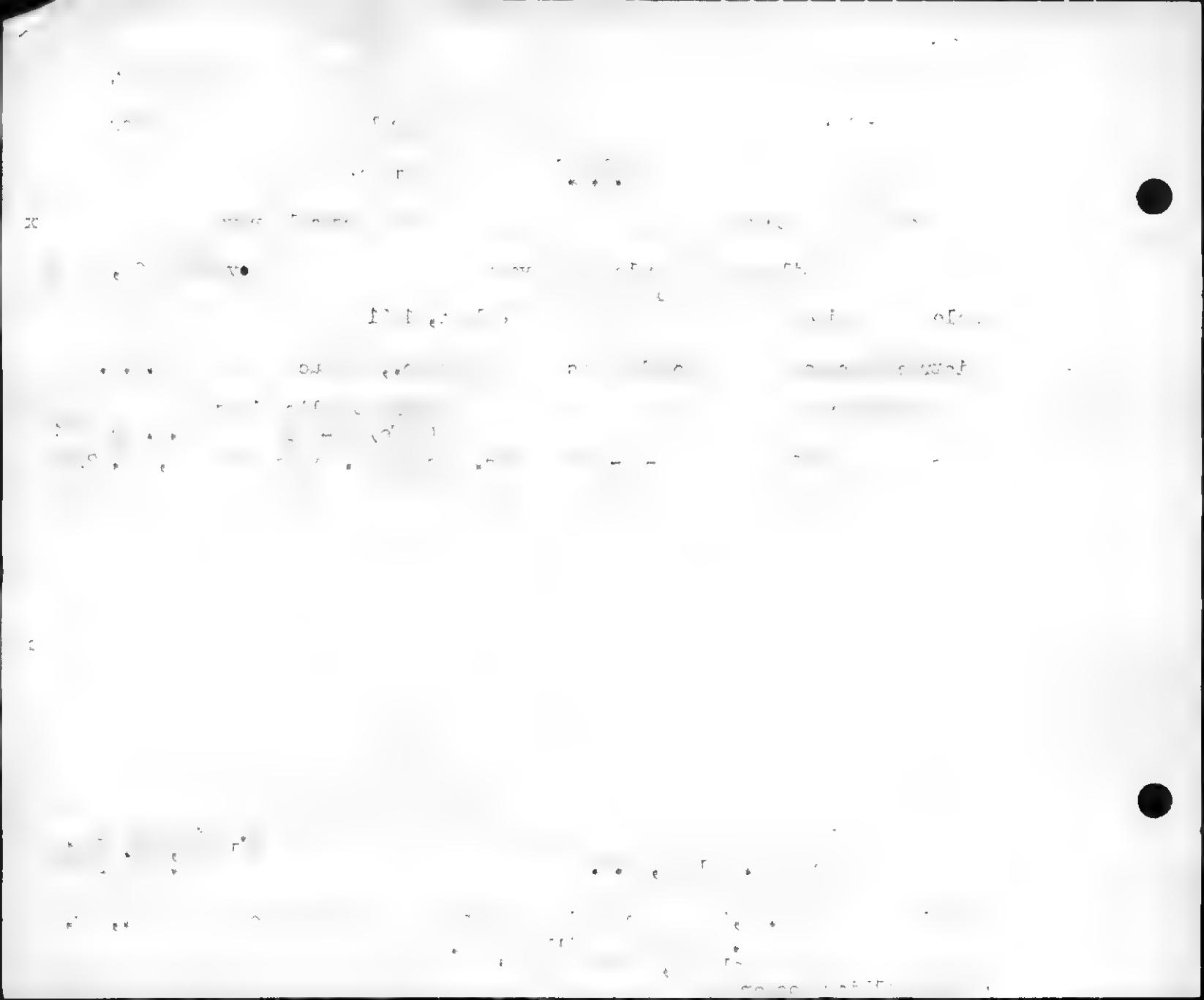
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15710

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15712

1 PLACE OF DEATH a. COUNTY Harford MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) South Main Street			d. STREET ADDRESS 210 Marshall Drive		
3. NAME OF DECEASED (Type or print) William Bartlett Evans			First William	Middle Bartlett	Last Evans
3. SEX Male	6. COLOR OR RACE White	7. MARRIED W. Dowd <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1921	9. AGE (In years at first birthday) 45 yrs	F. UNDER 1 YEAR Months 0
10. USUAL OCCUPATION (Give kind of work done during most of work no life even retired) District Manager			10b. KIND OF BUSINESS OR IND. STRY Bottled Gas	11. BIRTHPLACE (State or foreign country) Davis Co., Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Keller Evans			14. MOTHER'S MAIDEN NAME Margaret Ellis Hines		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW #2			16. SOC. A. SECURITY NO 406-12-8522	17. INFORMANT (Wife) 838-6956	Address P.O. Box #21
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Owensboro (County) Ohio (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gerald C. Palmer <i>m.d.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 11-23-66 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 8 Main Street Bel Air, Md. 21014 Nov. 23, 1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 26, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	23d. LOCATION (City or Town) Owensboro (County) Ohio (State)	
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25d. REC'D. BY REGISTRAR NOV 25 1966	25e. REGISTRAR'S SIGNATURE Charles J. Geiger



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15711

CERTIFICATE OF DEATH

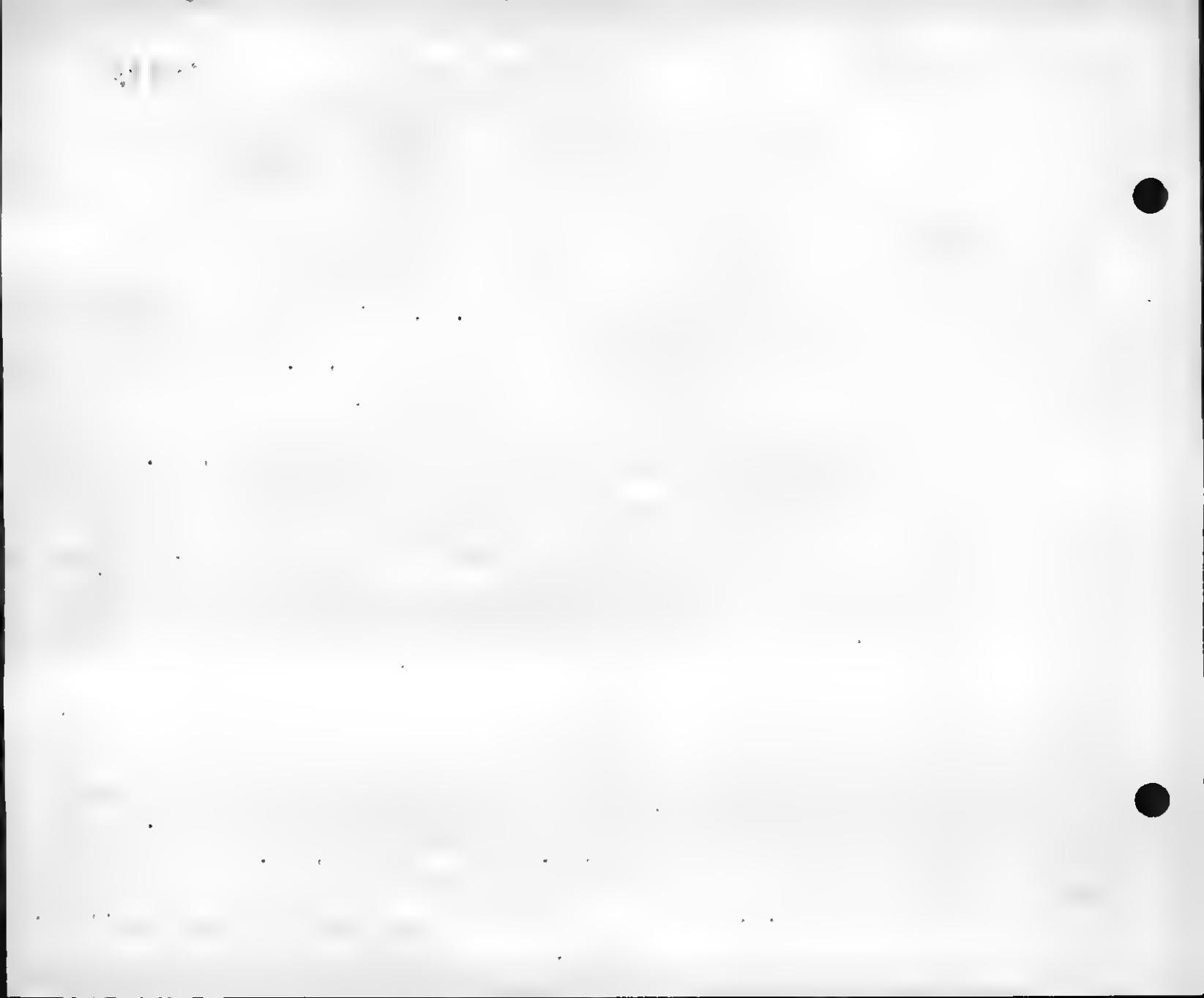
15713

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Whiteford		c. LENGTH OF STAY IN 16 82 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Whiteford		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First BRYAN	Middle P.	Lost	4. DATE OF DEATH Nov. 1, 1966	Month Nov.	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 16, 1884	9. AGE (In years at death 82 yrs.)	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Slate Splitter		10b. KIND OF BUSINESS OR INDUSTRY Slate		11. BIRTHPLACE (County & State, or foreign country) Whiteford, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Ford				14. MOTHER'S MAIDEN NAME Mary Ellen Allison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-03-0426		17. INFORMANT Owen B. Ford, Whiteford, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure. INTERVAL BETWEEN ONSET AND DEATH 6 mo							
17.5 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b) Hypertensive arteriosclerotic heart disease. DUE TO (c) And thrombosis of femoral left leg				10 years 3 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) Advanced pulmonary fibrosis + emphysema.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1958 to Nov 1966, that (I) (we) last saw the deceased alive on Nov 1966, and that death occurred at 9:15 A.M. from causes and on the date stated above.							
22a. SIGNATURE Edwin W. Whiteford, Jr.		22b. DATE SIGNED Nov. 2, 1966					
22c. PHYSICIAN'S NAME (Type) Edwin W. Whiteford, Jr.		22d. ADDRESS Whiteford, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 4, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Slate Ridge		23d. LOCATION (City or Town) (County) (State) Delta York Co., Pa.	
24. FUNERAL DIRECTOR John H. Hardine		ADDRESS Delta, Pa.		25a. RECD BY REGISTRAR DATE NOV 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15712

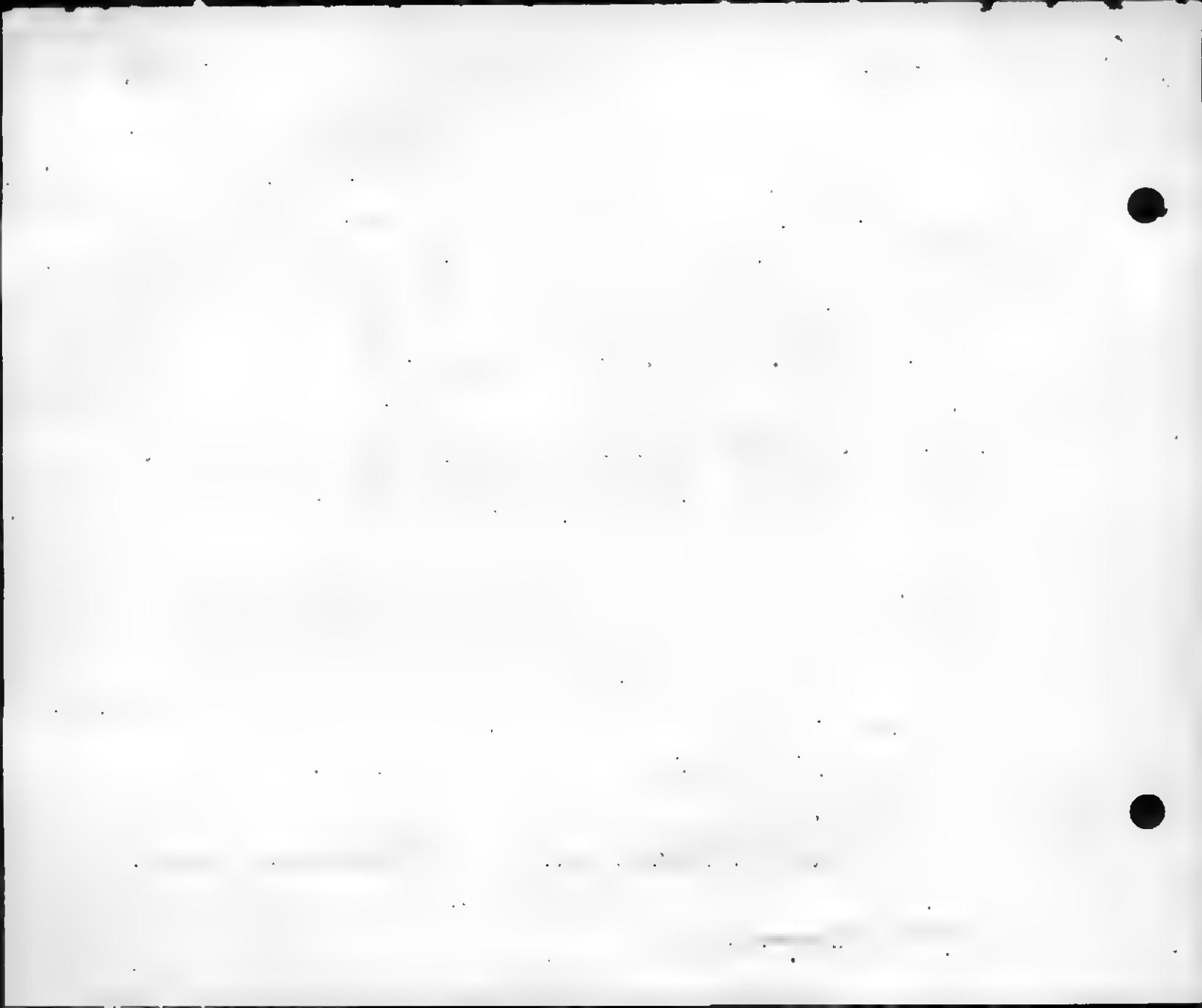
CERTIFICATE OF DEATH

15714

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First David	Middle 	Last GERBER
4. DATE OF DEATH Nov 24 1966	Month 	Day 	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 30 Jan 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman (Pldg.)		10b. KIND OF BUSINESS OR INDUSTRY Ord. Products	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sol Gerber		14. MOTHER'S MAIDEN NAME Elizabeth Bauer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Mar 46-66 078-22-9536	
17. INFORMANT Maryland State Patrol		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries pending completion of autopsy and toxicology studies DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Car accident		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:15 Nov 24 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rte. 40
20f. (City or town) Harford, near Belcamp, Maryland		(County) (State) Harford, Maryland	
21. I certify that (I) WILLIS H. STEPHENS, CPT., MC attended the deceased from DOA , 1966 , that (I) last saw the deceased at 8:15 A.M. DOA, 24 Nov 1966 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Willis H. Stephens Jr.			
22b. DATE SIGNED 25 Nov 66			
22c. PHYSICIAN'S NAME (Type) WILLIS H. STEPHENS, CPT., MC		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS Kirk Army Hospital, APG, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-28-66	
23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Willis H. Stephens Jr.		ADDRESS 	
Tarring Funeral home, Aberdeen, Maryland		25a. REC'D BY REGISTRAR DATE NOV 29 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15713

CERTIFICATE OF DEATH

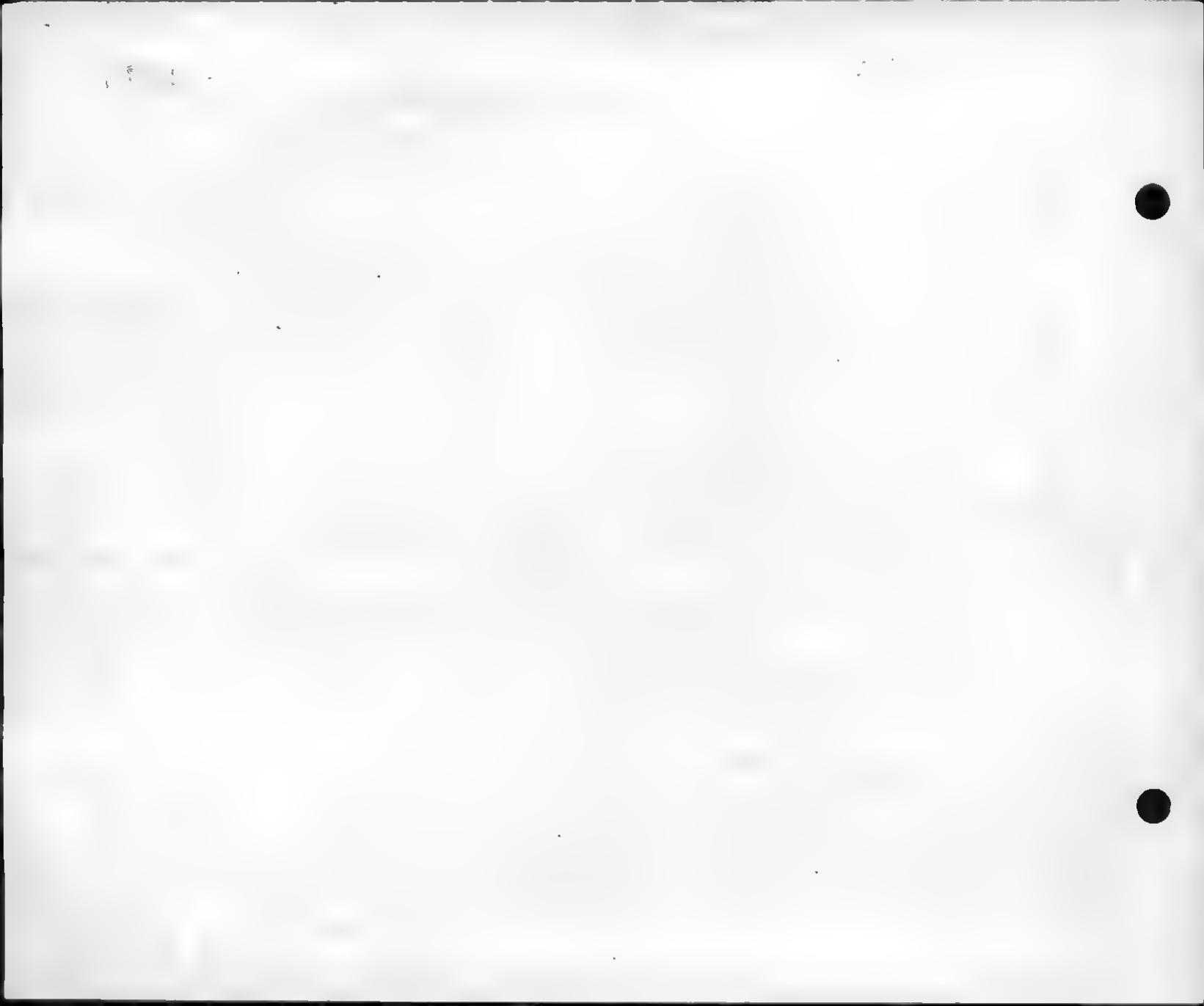
15715

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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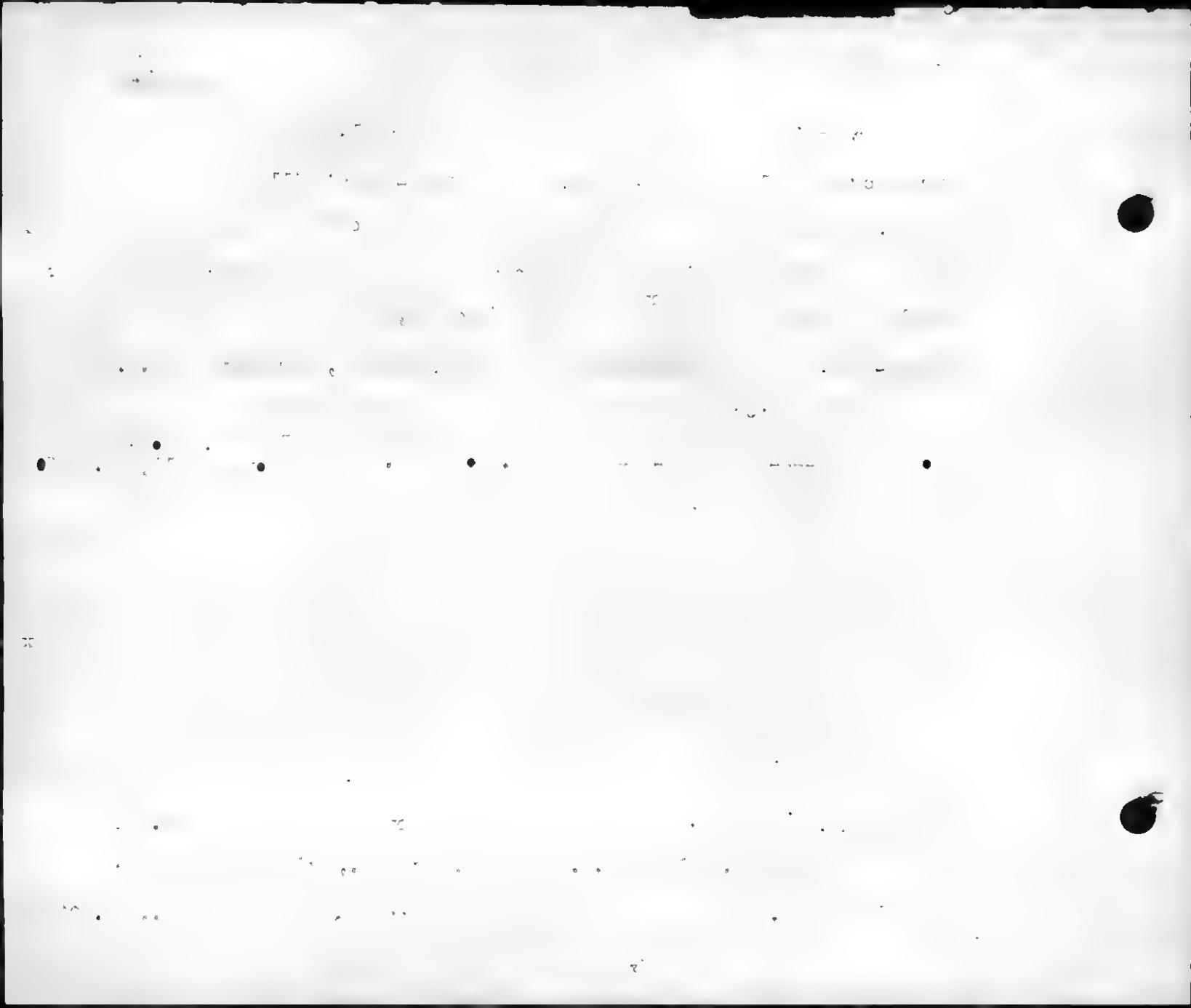
1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Harford MARYLAND		Maryland Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 9 days	
HAURE de GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Harford Memorial Hospital Willoughby Beach Rd.	
Harford Memorial Hospital		d. STREET ADDRESS Willoughby Beach Rd.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year	
Rosa		First	Middle
MARIE		Lost	November 2 1966
5. SEX		6. COLOR OR RACE	
FEMALE		White	
7. MARRIED WIDOWED		8. DATE OF BIRTH July 4, 1937	
WIDOWED		8. DATE OF BIRTH July 4, 1937	
9. NEVER MARRIED		9. AGE (In years last birthday) 73 yrs	
10. DIVORCED		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State or foreign country) Edgewood, Harford Co. Md		12. CITIZEN OF WHAT COUNTRY? SA	
13. FATHER'S NAME Morris M. Coulter		14. MOTHER'S MAIDEN NAME Emma Bunce	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes give war or dates of service		16. SOCIAL SECURITY NO 217-52-7522	
17. INFORMANT Mrs. Florence Spearman, Edgewood, Md.		Address	
18. CAUSE OF DEATH (Enter on 18 one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Peritonitis Rupture of diverticula - infection of peritoneum	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) A. S. C. T. D. and Obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 P.M.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-25, 1966, to 11-2, 1966, that (I) (we) last saw the deceased alive on 11-2, 1966, and that death occurred of 9:22 A.M. from causes and on the date stated above		22b. DATE SIGNED 11/2/66.	
22a. SIGNATURE Howard K. McComas		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Howard K. McComas		22d. ADDRESS Edgewood, Md. / Haure de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 5, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Trinity Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Joppa Harford Md	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		25a. RECEIVED BY REGISTRAR DATE NOV 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		15716			
1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Forest Hill		d. STREET ADDRESS Bynum Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Forest Hill		c. LENGTH OF STAY IN 1b 40 years		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bynum Road		e. DATE OF DEATH November 4, 1966		Month	Day	Year					
3. NAME OF DECEASED (Type or print) Nancy Catherine Haga		First	Middle	Last	4. DATE OF DEATH November 4, 1966	Month	Day	Year							
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1898	9. AGE (in years last birthday) 68 yrs.	10. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (County & State, or foreign country) Independence, Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Days	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager-Owner		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		14. MOTHER'S MAIDEN NAME Hattie Thorn		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-18-5200A		17. INFORMANT (Husband) Mr. Robert G. Haga		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerosis via dura (CV4)</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) S. Main St., Bel Air, Md. 21014	(County) Baltimore Co., Md.	(State) Md.	22b. DATE SIGNED Nov. 5, 1966				
21. I certify that (I) (this hospital) attended the deceased from 11-2, 1966 , to 11-4, 1966 , that (I) (we) last saw the deceased alive on 11-2, 1966 , and that death occurred at 11-2, 1966 M, from the causes and on the date stated above.		22a. SIGNATURE <i>Gerald C. Palmer</i>		22c. PHYSICIAN'S NAME (Type) Gerald C. Palmer, M.D.		22d. ADDRESS S. Main St., Bel Air, Md. 21014									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 7, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens		23d. LOCATION (City, town or county) Baltimore, Harf. Co., Md. 21014									
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>		ADDRESS W. Broadway & Williams Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR NOV 9 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									
Joseph William Foster															



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

15715

1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rutledge

c. LENGTH OF STAY IN 1b

76 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Park Road

3. NAME OF
DECEASED
(Type or print)

George Leo Hanlon

First

Middle

Last

4. DATE
OF
DEATHMonth
NovemberDay
25Year
1966

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give name or dates of service)

No 219-36-2415 Mrs. Ethel Lynch

Federal Hill Road

Rocks, Md. 211+1

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause } (b)

(a), stating the underlying } DUE TO

cause last } (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?Unknown YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

None

20c. TIME OF INJURY Month, Day, Year

Hour a.m. —

p.m. 19

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (the hospital) attended the deceased from 45

saw the deceased alive on 4/15

1966, and that death occurred at 10 A.M. from the causes and on the date stated above

22a. SIGNATURE

John F. Wiltby Jr. - at direction of

22c. PHYSICIAN'S NAME (Type)

Dr. Gerald Palmer

M.D.

ATTENDING PHYS.

MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

Jarrettsville, Md. 21084

(State)

23a. BURIAL, CREMATION, DATE THEREOF

REMOVAL (Specify)

Burial 11/28/1966

St. Johns

ADDRESS

Charles E. Kurtz Jarrettsville, Md.

23b. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

Hyde Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Charles E. Kurtz

Jarrettsville, Md.

25a. REC'D BY REGISTRAR

NOV 28 1966

Charles Judge

25b. REGISTRAR'S SIGNATURE

DATE

20M 5-63

1

15717

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE Maryland b. COUNTY Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rutledge

d. STREET ADDRESS

Park Road

e. IS RESIDENCE
ON A FARM?
YES NO

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. MEDICAL CERTIFICATION

14. INTERVAL BETWEEN
ONSET AND DEATH

immediate

15. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

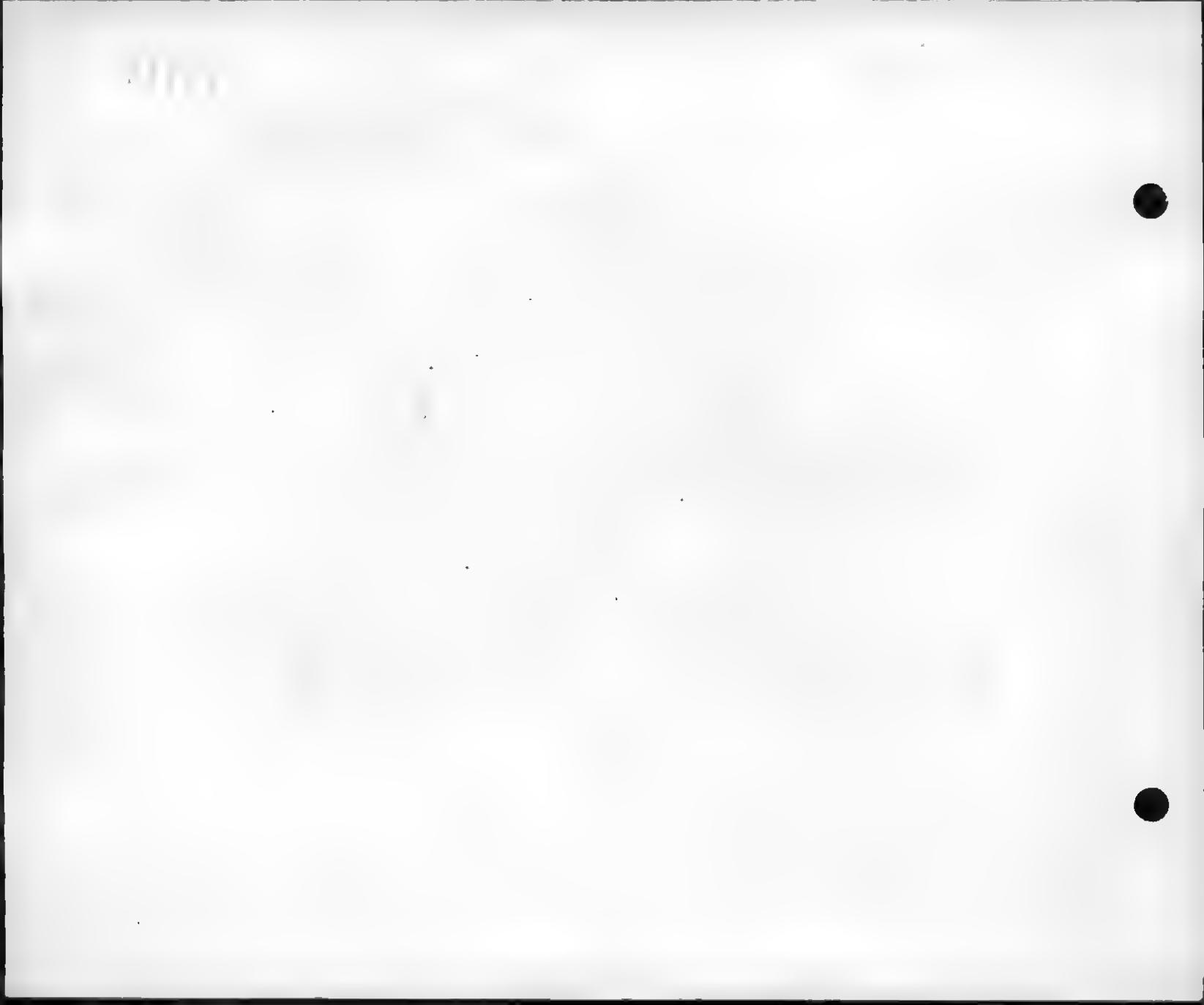
15716

CERTIFICATE OF DEATH

15718

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Maryland</i> b. COUNTY <i>HARFORD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hautre de Grace</i>		c. LENGTH OF STAY IN 1b <i>30 days</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hartford Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <i>Hartford Memorial Hospital</i>		f. STREET ADDRESS <i>Rt 21 320 Big Ft. Pike</i>	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William Worthington</i>		First <i>W</i> Middle <i></i> Last <i>Hopkins</i>	4. DATE OF DEATH Month <i>November</i> Day <i>25</i> Year <i>1966</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>SEPT. 7, 1898</i>		9. AGE (In years from birthday) <i>68</i> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DAIRY</i>	
11. BIRTHPLACE (County & State or foreign country) <i>DARLINGTON, MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>EDWARD C. HOPKINS</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH OBERLANDER</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>314-34-4467</i>	
17. INFORMANT <i>Mrs. ERNEST HENRY</i>		18. INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peritonitis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Perforation of stomach</i> (c) <i>Linitis plastica</i>		20. DUE TO <i>3 weeks</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 26</i> , 1966, to <i>Nov 25</i> , 1966, that (I) (we) last saw the deceased alive on <i>Nov 25</i> , 1966, and that death occurred on <i>Nov 25</i> , 1966, from causes and on the date stated above			
22a. SIGNATURE <i>James M.C. Finney</i>		22b. DATE SIGNED <i>11-28-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES M.C. FINNEY</i>		22d. ADDRESS <i>Hautre de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>Nov. 29, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>DARLINGTON</i>		23d. LOCATION (City or Town) (County) (State) <i>DARLINGTON, HARFORD, Md.</i>	
24. FUNERAL DIRECTOR <i>John H. Hartman, DELTA, PA.</i>		25a. ADDRESS <i></i>	
		25b. REC'D BY REGISTRAR DATE <i>NOV 30 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

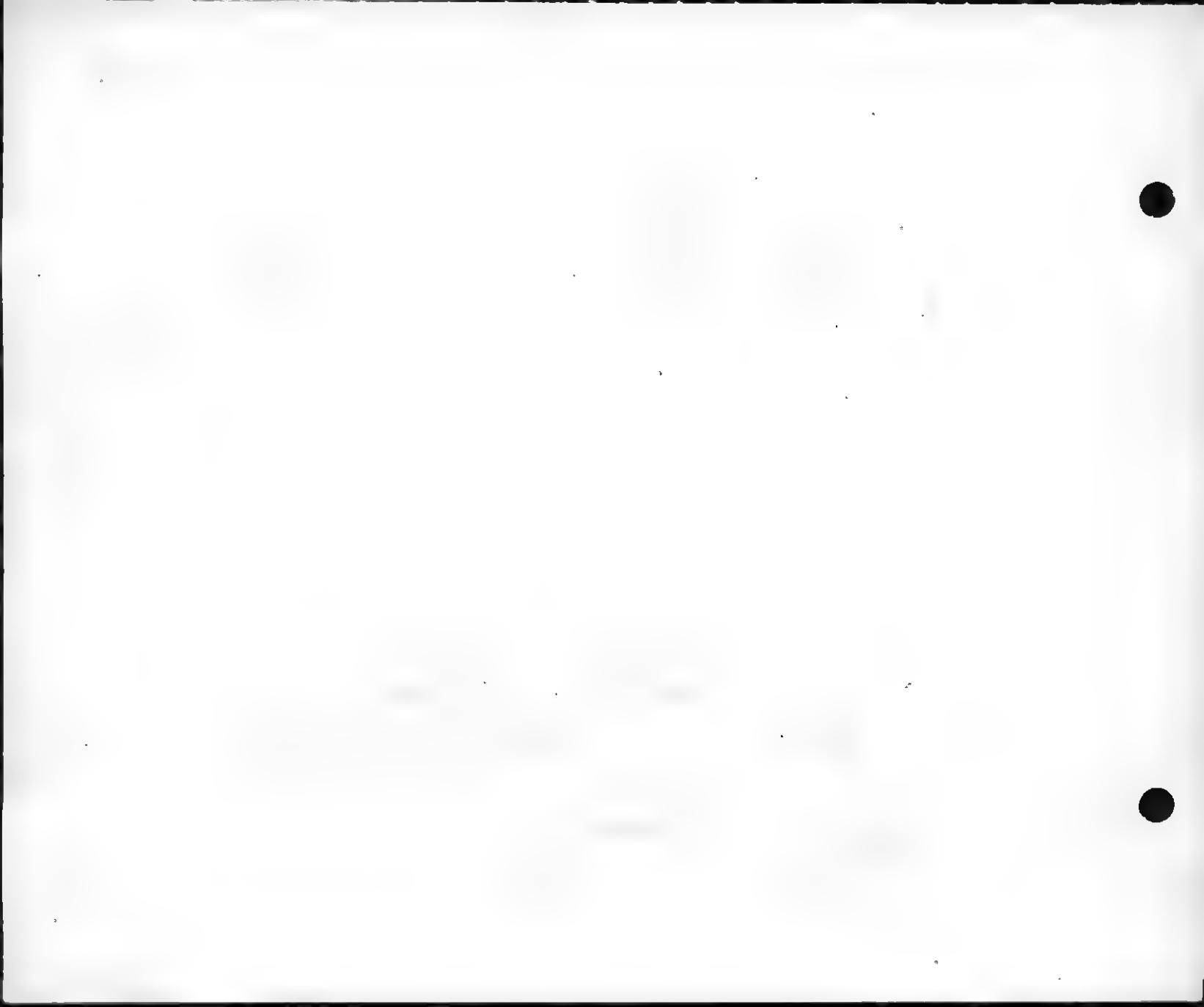
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15717
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH						15719							
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived in institution, Residence before admission) a. STATE		b. COUNTY									
Harford		MARYLAND		Md.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Harford		Beltsville		Beltsville									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
DOA Harford Memorial Hospital		13223 Longmeadow Dr.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH Month Day Year									
Dale C. Hudgins				November 11 1966									
5. SEX		6. COLOR OR RACE		7. MARRIED WIDOWED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. UNDER Months		11. UNDER 24 HRS Days Hours Min	
F		White		NEVER MARRIED		Aug 21-1933		33 yrs		Months		Days Hours Min	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA							
Student		U. of Md.		Trenton N.J.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. INFORMANT		Address							
Frank Chestnut		Helen S. Akell		Frank Chestnut		Yardley Pa							
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. SOCIAL SECURITY NO		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. INTERVAL BETWEEN ONSET AND DEATH							
No				Fracture SK 11									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause factors.		(b)		DUE TO									
		(c)		DUE TO									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAMED DISEASE CONDITION GIVEN IN PART I(o)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		11-12-66									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Nov. 11 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.) JEH Hahaway Perryville Cecil Md.									
21. ACTUAL SIGNATURE		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bethany, Md.</u>											
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Nov 16, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.							
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15718

CERTIFICATE OF DEATH

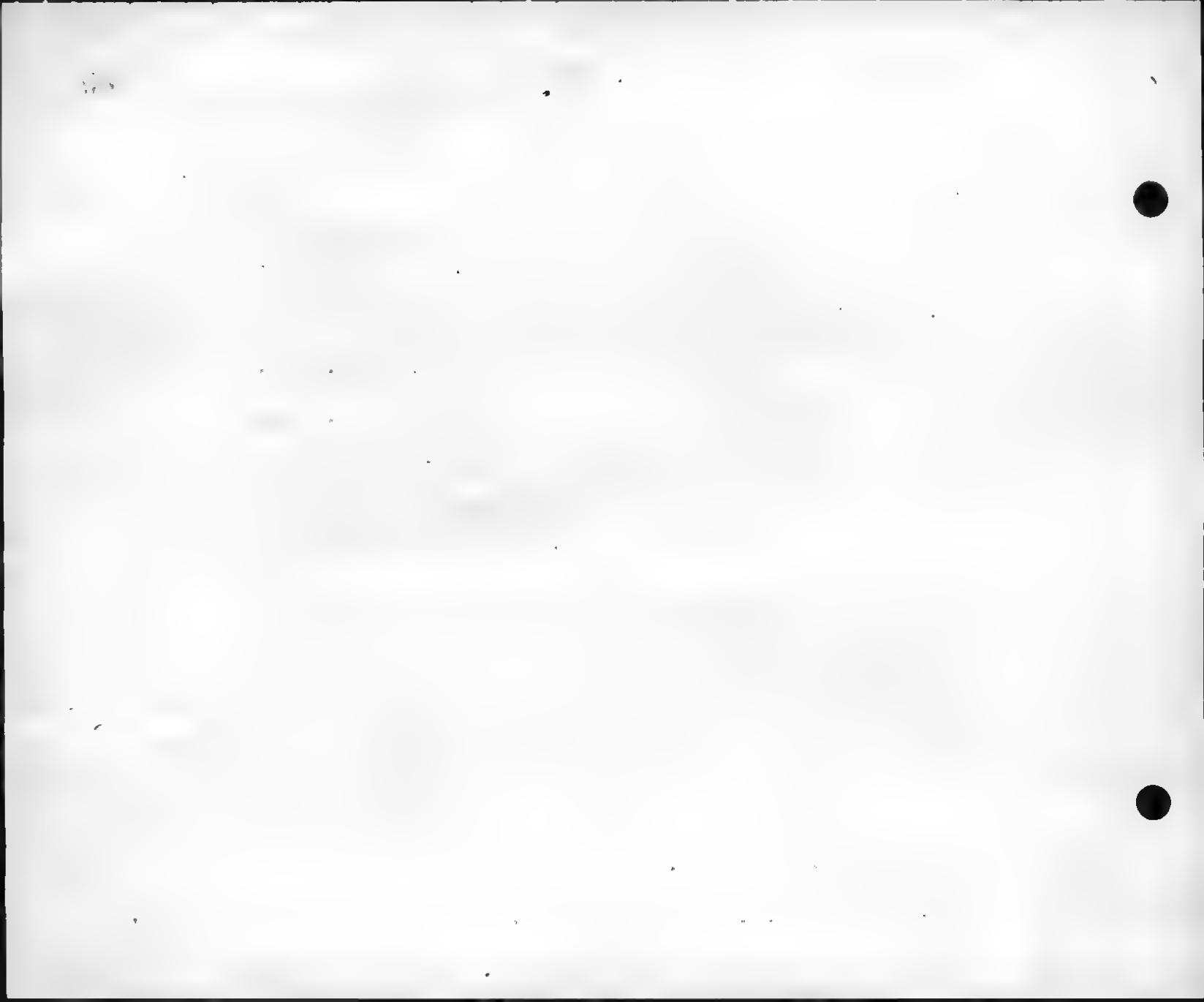
15720

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de GRACE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARY/nd b. COUNTY HARFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de GRACE d. STREET ADDRESS 317 Wilson St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Jackson
4 DATE OF DEATH	Month Nov	Year 5 19 66	Day 5
5 SEX Male	6 COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-3-66
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) N/A	10b KIND OF BUSINESS OR INDUSTRY N/A	11 BIRTHPLACE (County & State, or foreign country) Harford Co., Md.	12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME Alvin Jackson	14. MOTHER'S MAIDEN NAME Celma D. Jackson Fisher		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mother--Same as 2 C & D	Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) (4 months Utter Gestation) stating the underlying cause DUE TO lost (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 11/3 1966 to 11/3 1966 , that (I) (we) last saw the deceased alive on 11-3 1966 , and that death occurred at 11.5 M , from causes and on the date stated above.			
22a SIGNATURE Chen MD	M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b DATE SIGNED 11/4/66
22c PHYSICIAN'S NAME (Type) C. Chan, M.D.	22d. ADDRESS		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11-5-66	23c NAME OF CEMETERY OR CREMATORIAL Union A.M.E. Cemetery	23d LOCATION (City or Town) Aberdeen (County) Md. (State)
24 FUNERAL DIRECTOR Charles J. Tamm	ADDRESS Tamm Funeral Home, Aberdeen, Md.	25a. RECD BY REGISTRAR NOV 7 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15719

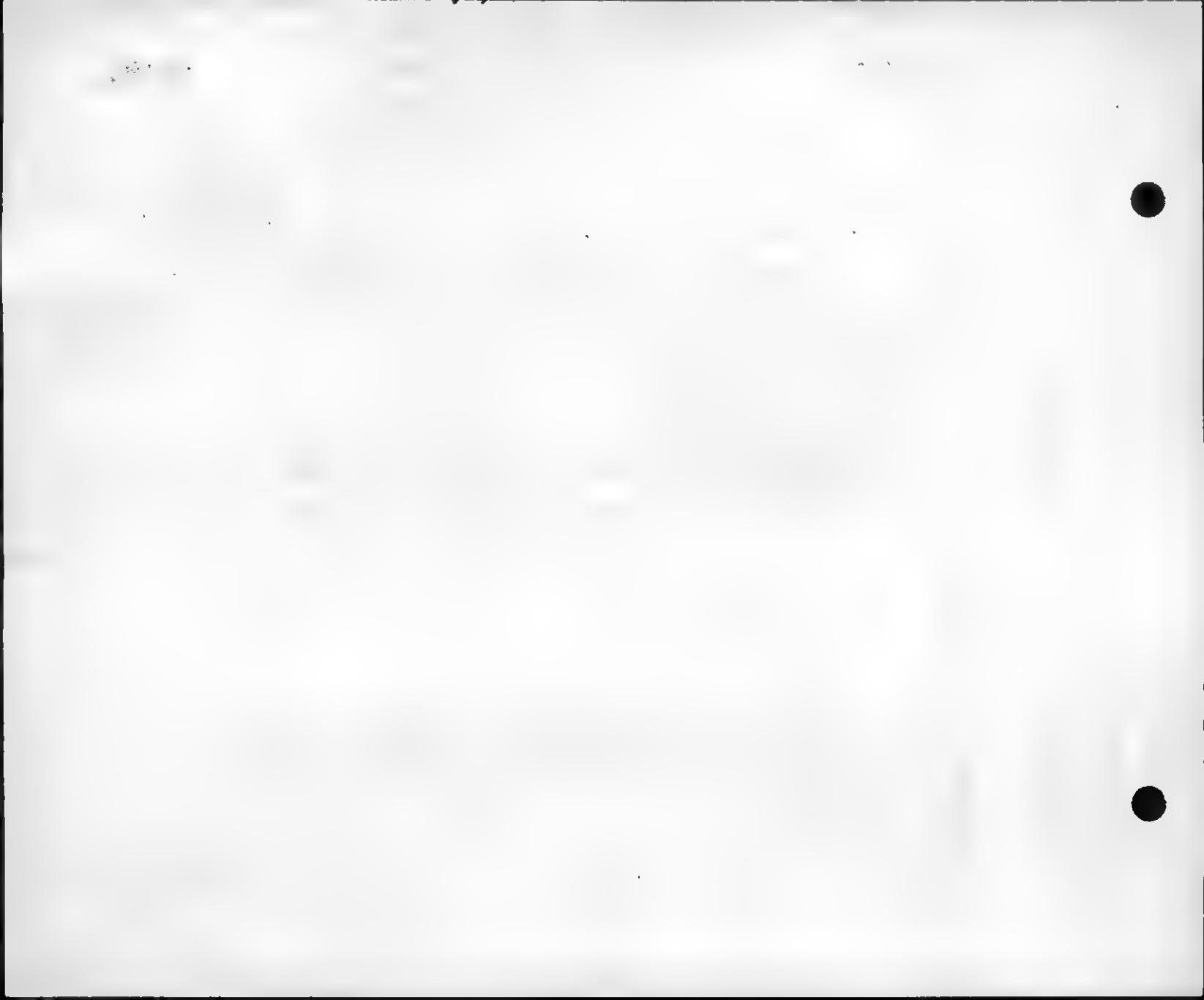
CERTIFICATE OF DEATH

15721

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD de GRACE</u>		c. LENGTH OF STAY IN TB <u>19 hrs</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>HARFORD Memorial Hospital</u>		e. STREET ADDRESS <u>107 ALTON AVE</u>					
3 NAME OF DECEASED (Type or print) <u>MARK</u>		First <u>ATAN</u>	Middle <u>Johnson</u>				
4 SEX <u>Male</u>	5 COLOR OR RACE <u>W</u>	6 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7 DATE OF BIRTH <u>6-14-63</u>				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>					
11 BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13 FATHER'S NAME <u>Carl Edward Johnson</u>		14 MOTHER'S MAIDEN NAME <u>Doris E. King</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>none</u>					
17 INFORMANT <u>Carl Edward Johnson, 107 Alton Ave.,</u>		Address <u>Aberdeen, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration and illness</u> DUE TO <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Leptospirosis</u> (b) <u>Leptospirosis</u> DUE TO <u>Septicemia</u> (c) <u>Septicemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u> <u>20 hour</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <u>Bel Air</u>	20f. (City or town) <u>Bel Air</u>	(County) <u>Harford</u>	(State) <u>Md.</u>	
21 I certify that (I) (this hospital) attended the deceased from <u>11-12</u> , 19 <u>66</u> , to <u>Nov 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>11-13 1966</u> and that death occurred at <u>7 AM</u> , from causes and on the date stated above.				22b. DATE SIGNED <u>11/13/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>John D. Year</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <u>HARFORD de GRACE, Md</u>				
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 16, 1966</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) <u>Bel Air</u>	(County) <u>Harford</u>	(State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas</u>		ADDRESS <u>Son, Abingdon, Md. 21002</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	DATE <u>NOV 15 1966</u>	



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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15722

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please ~~keep~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Bel Air	
c. LENGTH OF STAY IN 1b 32 years		d. STREET ADDRESS 1110 Moore's Mill Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Moore's Mill Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Martha	Middle May	Last Jones
4. DATE OF DEATH Month November	Day 1, 19	Year 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (County & State, or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel W. Thompson		14. MOTHER'S MAIDEN NAME Anna Parker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-34-2574	
17. INFORMANT (Husband) Mr. F. Russell Jones		18. AGE (In years last birthday) 67 yrs.	
		19. IF UNDER 1 YEAR Months 11 Days 0 Hours 0 Min. 0	
		20. IF UNDER 24 HRS.	
		21. ADDRESS 1110 Moore's Mill Rd. Bel Air, Md. 21014	
22. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		1 week	
534X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Right side hemiplegia		3 months	
DUE TO (b) Right side hemiplegia		?	
DUE TO (c) Cerebral vascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 4, 1966 , to Nov. 1, 1966 , that (I) and last saw the deceased alive on Oct. 31, 1966 , and that death occurred at 6A M, from the causes and on the date stated above.		22b. DATE SIGNED Nov. 1, 1966	
22c. SIGNATURE Willard P. Hudson, M.D.		22d. ADDRESS Forest Hill, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 3, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Meth. Ch. Cem.		23d. LOCATION (City, town or county) (State) Fountain Green, Harf. Co., Md.	
24. FUNERAL DIRECTOR Joseph William Foster		25a. ADDRESS W. Broadway & Williams Bel Air, Maryland 21014	
		25b. REC'D BY REGISTRAR NOV 2 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

X

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15721

CERTIFICATE OF DEATH

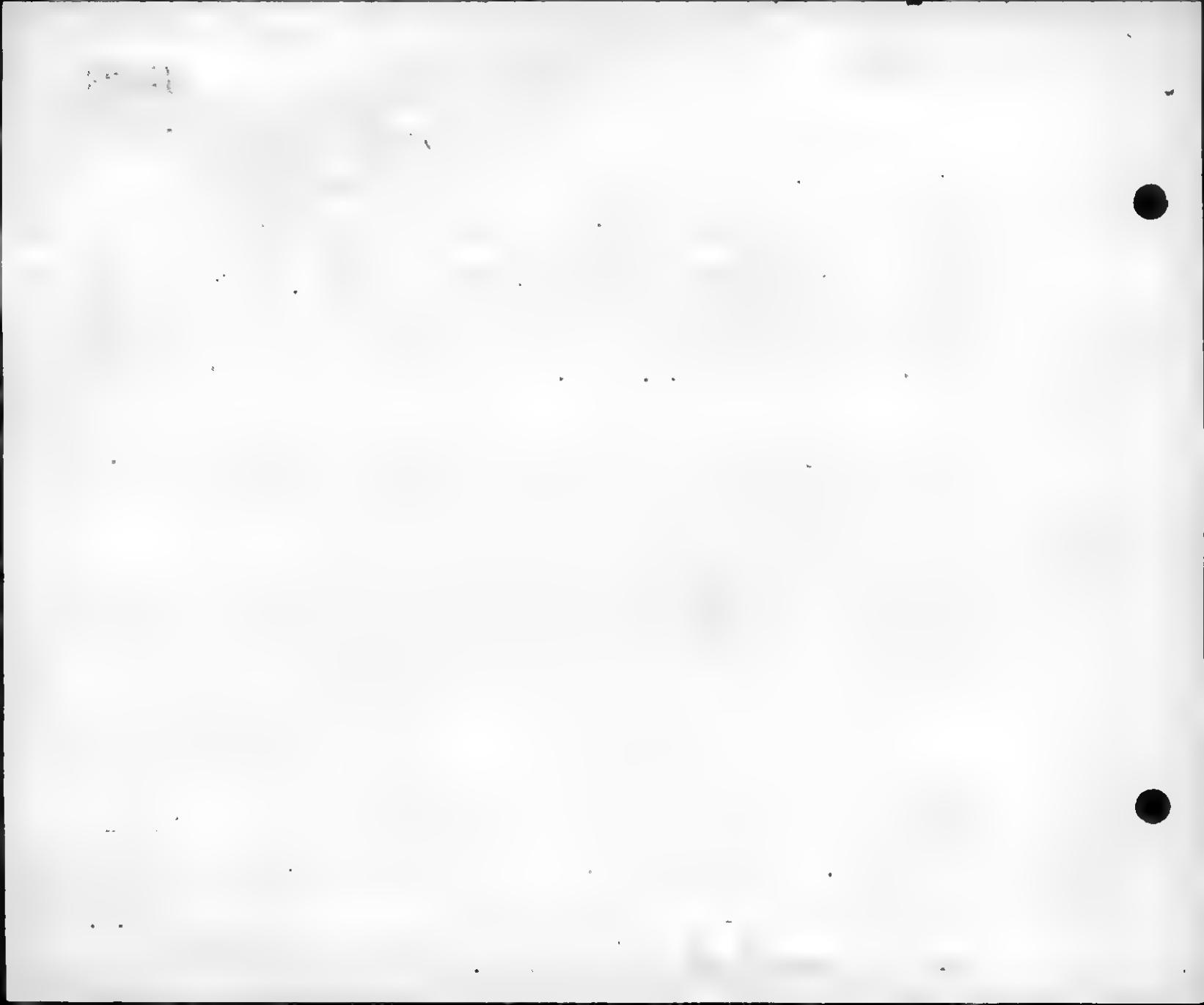
15723

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician.

Page 4 may be retained by the hospital or attending physician. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY HARFORD		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD DE GRACE		c. LENGTH OF STAY IN 1b 12 hrs.	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD Memorial Hospital		e. STREET ADDRESS RD 1 Box 188	
3. NAME OF DECEASED (Type or print) SAUNDERS		First NOAH	Middle LYALL
4. SEX Male	5. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 12/26/09
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artl. Repairman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. AIG	
13. FATHER'S NAME Thomas Lyall		11. BIRTHPLACE (County & State or foreign country) Ashe Co., N.C.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 245-03-0160	
17. INFORMANT Lillian Lyall, Aberdeen, Md.		18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) massive gastrointestinal hemorrhage	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) Gastric ulcer DUE TO (c) Paroxysmal heat of fauces & liver metastasis	
INTERVAL BETWEEN ONSET AND DEATH 3 days			
19. PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Nov. 18 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Churchville, Maryland
20f. (City or town) Churchville		(County) Maryland	
(State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from Nov. 18 1966 to Nov 18, 1966 that (I) (we) last saw the deceased alive on Nov. 18 1966 and that death occurred at 11:35 A.M. from causes and on the date stated above			
22. SIGNATURE Ralph Harky		22b. DATE SIGNED 11-18-66	
22c. PHYSICIAN'S NAME (Type) J. Ralph Harky, M.D.		22d. ADDRESS Churchville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11-20-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Big Ridge Cemetery		23d. LOCATION (City or Town) Jefferson, N.C.	
24. FUNERAL DIRECTOR Charles J. Harky		Tarring Funeral Home RECD BY REGISTRAR NOV 21 1966	
		25b. REGISTRAR'S SIGNATURE Charles J. Harky	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15722

CERTIFICATE OF DEATH

15725

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-HAVER DE GRACE		c. LENGTH OF STAY IN 1b 60 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA ALBERDA	First	Middle	Last
4. DATE OF DEATH NOV. 1 1966	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7 1882
9. AGE (In years last birthday) 84 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & State, or foreign country) NO
12. CITIZEN OF WHAT COUNTRY? US-A.	13. FATHER'S NAME BENJAMIN HARRIINS		
14. MOTHER'S MAIDEN NAME EMMA JONES	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. —	17. INFORMANT GEORGE L OSBORN, HAVER DE GRACE MD 2	Address R.D. #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old age			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Anemia	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 30, 1966 to NOV 1, 1966 that (I) (we) last saw the deceased alive on NOV 1, 1966 and that death occurred at 5 AM, from the causes and on the date stated above.			
22a. SIGNATURE J. Edward Yur		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/2/66
22c. PHYSICIAN'S NAME (Type) JOYCE D. YUR		22d. ADDRESS HAVER DE GRACE MD	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 3, 1966	23c. NAME OF CEMETERY OR CREMATORIAL WESLEYAN CHAPEL
23d. LOCATION (City, town or county) HARFORD Co.		(State) MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Y. Madison Mitchell HAVER DE GRACE NO. 1966		ADDRESS	25a. REC'D. BY REGISTRAR NOV 7 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15723

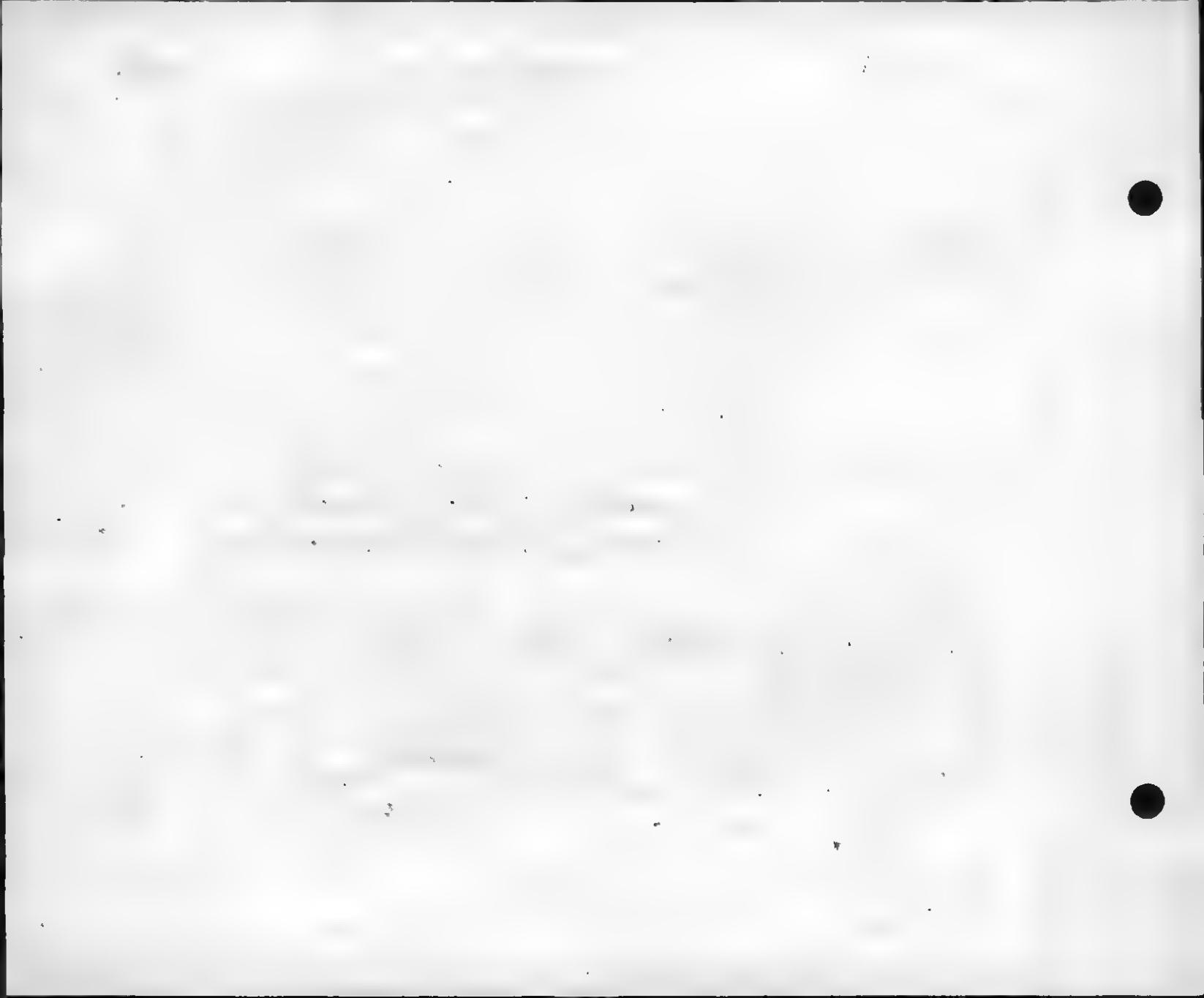
CERTIFICATE OF DEATH

15726

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Harford		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin		c. LENGTH OF STAY IN 1b 25 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fork Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin	
f. STREET ADDRESS Fork Road Baldwin, Md. 21012		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Elmer		First Elmer	Middle Jerry
Last Plowman		4 DATE OF DEATH 11 7 1966	Month Day Year
5 SEX Male	6 COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 2-13-1906	9. AGE (In years last birthday) 60 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Planner		10b KIND OF BUSINESS OR INDUSTRY Martin Marictta	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer F. Plowman		14. MOTHER'S MAIDEN NAME Anna Zippeling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-01-2416	17. INFORMANT Mrs Inez Plowman Fork Road Baldwin, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 47: 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO		19. INTERVAL BETWEEN ONSET AND DEATH 15 min Hypertensive Cardiac Dis. 6 yrs.	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Renal Calculi: Obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6121/65
20f. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/21/65 to 11/7/66 that (I) (we) last saw the deceased alive on Nov 7, 1966 and that death occurred at 1240 M, from causes and on the date stated above.		22b. DATE SIGNED 11/8/66	
22c. SIGNATURE Clifford F. Hudson		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS CLIFFORD F. HUDSON FORK, MD
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-10-1966	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial
24. FUNERAL DIRECTOR Lassahn Funeral Home 1401 Belair Road		ADDRESS 36	25a. REC'D BY REGISTRAR DATE NOV 9 1966 25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

3-1-66
10
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transport permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the PM3. Page 5 may be retained for your files.

15724

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15727

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sharon Acres Road		d. STREET ADDRESS Sharon Acres Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GUY		4. DATE OF DEATH Month November Day 17 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/15/1925
9. AGE (In years last birthday) 41 yrs	10. BUSINESS OR INDUSTRY 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Gasper Pritt		14. MOTHER'S MAIDEN NAME Pattie Rose	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 232-34-4176	
17. INFORMANT Mrs. Arlen Pritt		Address Sharon acres Forest Hill Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Diffuse fibrinopurulent peritonitis</u> (c) <u>Perforated gastric ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial	
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Concreete W. Virginia	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 11/18/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Philip J. Harvey Sons 2024 Galloway St.		25a. RECD BY REG STRR DATE NOV 23 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

1
TO DEATH: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in an event within 72 hours after death.

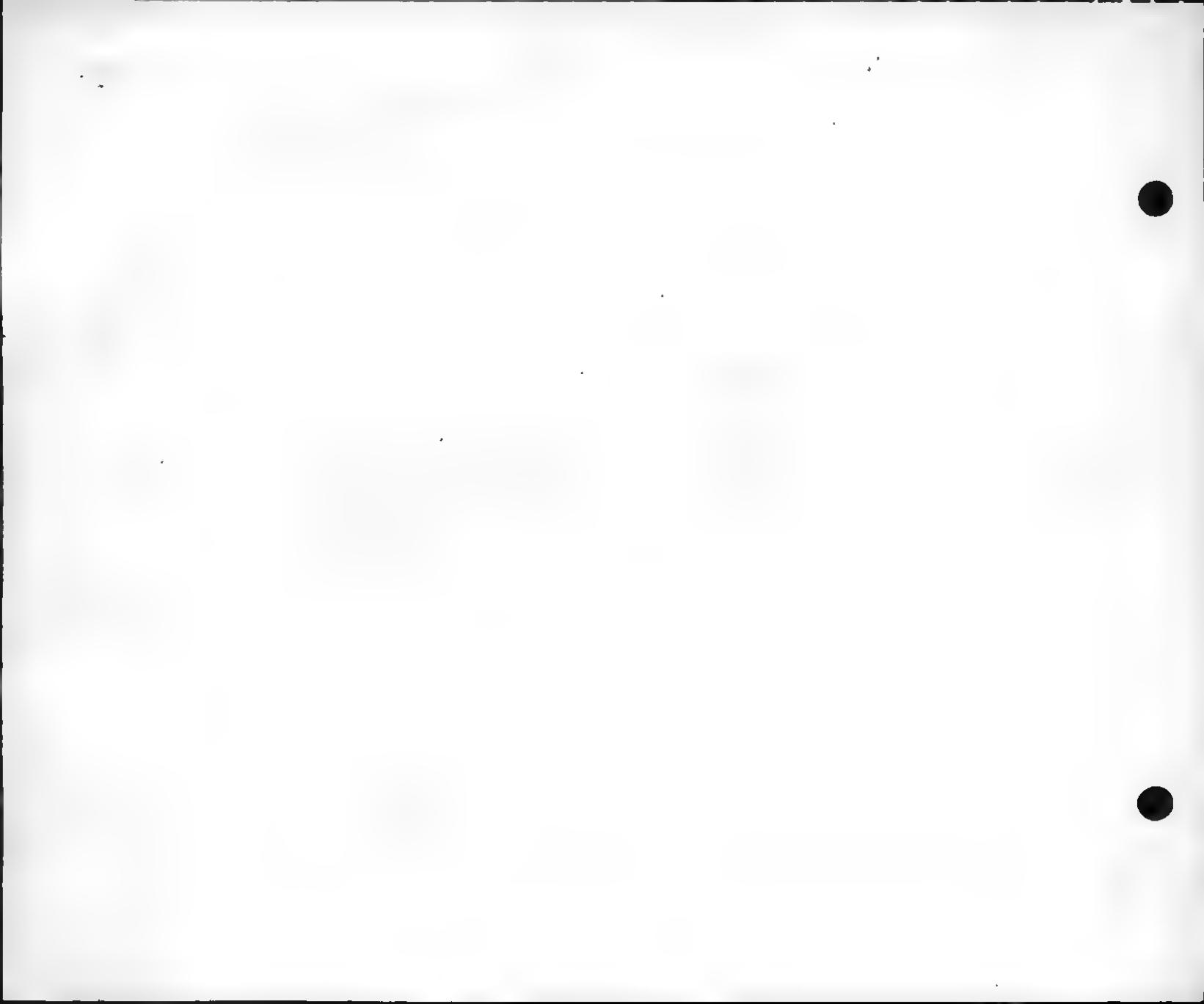
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15725

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15728

1. PLACE OF DEATH a. COUNTY <i>Hanover Co.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air (Rural)</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Churchville Road</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Hanover</i>			
3. NAME OF DECEASED (Type or print) <i>Robert Lee Pruitt</i>				4. DATE OF DEATH <i>November 12 1966</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	8. DATE OF BIRTH <i>10-1-43</i>	9. AGE (In years lost birthday) <i>23 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Assistant manager</i>				11. BIRTHPLACE (State or foreign country) <i>Wilkes Co., N.C.</i>			
13. FATHER'S NAME <i>Aldine Pruitt</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <i>244-62-4073</i>			
17. INFORMANT (With) <i>Wife</i> 838-6374 Address <i>2801, Box #382C, Fallston, Maryland 21047</i>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Asphyxia due to CO</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO last. (c)			
19. WAS A TOPSY PERFORMED? <i>NO</i>				20. MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Piped exhaust into car</i>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>3 pm 11-12 1966</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <i>Churchville Rd.</i> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bel Air</i> 20f. (City or town) <i>Bel Air</i> (County) <i>Hanover</i> (State) <i>Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. DATE SIGNED <i>11-12-66</i>			
ACTUAL SIGNATURE <i>Loralee Palmer</i> M.D. EXAMINER'S NAME (Type) <i>Gerald E. Palmer M.D.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bel Air, Md.</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 14, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Memorial Gardens</i>		23d. LOCATION (City or Town) <i>Bel Air, Harford Co., Maryland 21014</i> (County) <i>Harford Co.</i> (State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Joseph William Foster</i> ADDRESS <i>W. Broadway & Williams St.</i> DATE <i>NOV 14 1966</i>				25a. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15726

CERTIFICATE OF DEATH

15728

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD GRACE		c. LENGTH OF STAY IN b 10 days	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR		e. STREET ADDRESS RFD 2 Box 30	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mauda Virginia Roberts		First Mauda	Middle Virginia
4. DATE OF DEATH November 27 1966	Month November	Day 27	Year 1966
5. SEX Female	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH September 14, 1870		9. AGE (In years lost birthday) 76 yrs	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) U.A.	
13. FATHER'S NAME T. H. Sawyers		14. MOTHER'S MAIDEN NAME Eliza J. Huddleston	
16. SOCIAL SECURITY NO 212-32-4622		17. INFORMANT (Sew) 838-6139 Mr. DONNIE K. ROBERTS RECD #2 Box #30 BEL AIR, MARYLAND 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Q.S.C. U.P. - Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chalcyctosigmoid - colic		DUE TO (b) Q.S.C. U.P. - Pneumonia DUE TO (c) Chalcyctosigmoid - colic	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11/23/66 Admitted for "C"		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 11-18, 1966, to Nov 27, 1966, that (I) (we) last saw the deceased alive on November 27, 1966, and that death occurred at 12:40 P.M. from causes and on the date stated above.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 20f. (City or town)		(County) (County)	
(State) (State)		(State) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-18 , 1966, to Nov 27, 1966 , that (I) (we) last saw the deceased alive on November 27, 1966 , and that death occurred at 12:40 P.M. from causes and on the date stated above.		22b. DATE SIGNED 11/27/66	
22c. SIGNATURE Wm. K. Brendle		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) William K. Brendle, M.D.		22d. ADDRESS Hause de Grace, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF December 1, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Summerfield Meth. Ch. Cem.
23d. LOCATION (City or Town) Fries, Grayson Co., Virginia		(County) (County)	
(State) (State)		(State) (State)	
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014	25a. REC'D BY REGISTRAR DATE NOV 29 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Harford</i> b. CITY OR TOWN (if outside corporate mts., write RURAL and give nearest town) <i>Grace de Grace</i>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) d. STATE <i>MARYLAND</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rock</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>Federal Hill Road</i>	
3 NAME OF DECEASED (Type or print) <i>JAMES CLARENCE ROBINSON</i>		4 DATE OF DEATH <i>November 25 1966</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>Col.</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH <i>12/17/1887</i>
10a USUAL OCC. OR PAY (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		11 BIRTHPLACE (County & State or foreign country) <i>Fallston, Maryland</i>	
13. FATHER'S NAME <i>Lloyd Barnes Robinson</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Rainbow</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>218-12-4084</i>	
17. INFORMANT <i>Mrs. Grace A. Robinson</i>		18. ADDRESS <i>Federal Hill Road, Rocks, Md.</i>	
19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>)			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>None</i>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 19, 1966</i> to <i>Nov. 25, 1966</i> , that (I) <input checked="" type="checkbox"/> lost sight of the deceased alive on <i>Nov. 25, 1966</i> , and that death occurred at <i>1/2</i> M, from causes and on the date stated above.		22b. DATE SIGNED <i>Nov. 26, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Willard P. Hudson, M.D.</i>		22d. ADDRESS <i>Forest Hill, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/29/1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. James M.E.</i>
24. FUNERAL DIRECTOR <i>Charles E. Kurtz</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		26. DATE <i>NOV 29 1966</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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15728

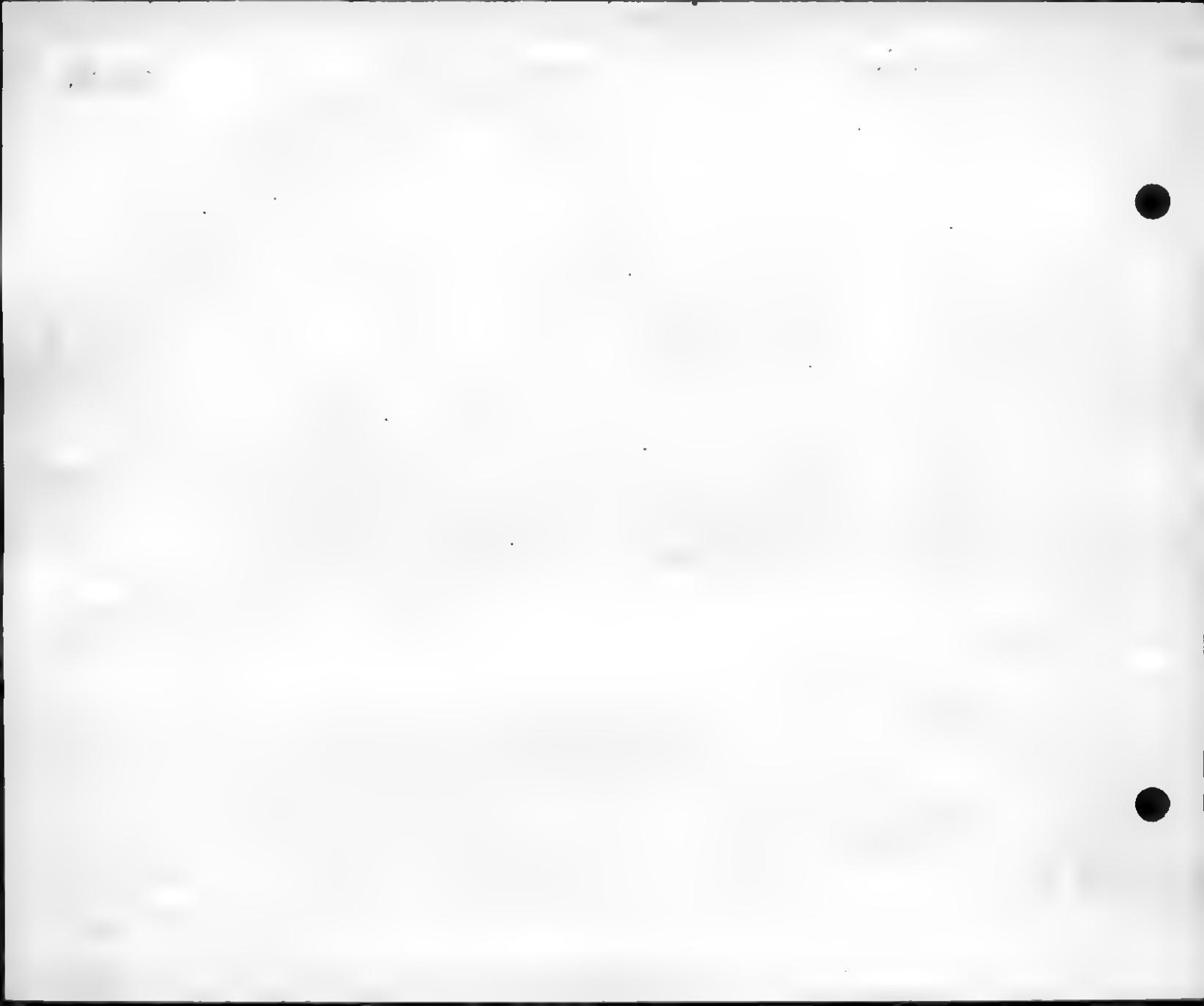
CERTIFICATE OF DEATH

15731

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. On any event, within 72 hours after death

1 PLACE OF DEATH: a COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Harford MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
3 NAME OF DECEASED (Type or print)		d. STREET ADDRESS Plum Tree Rd. Rd 3	
George William Rufenacht		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH July 15, 1898
9. AGE (in years last birthday) 68 yrs	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if ret'd) Ship Foreman	10b KIND OF BUSINESS OR INDUSTRY Infg Barn Equip	11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md
12 CITIZEN OF WHAT COUNTRY U.S.	13. FATHER'S NAME Herman Rufenacht		
14. MOTHER'S MAIDEN NAME Sophia Pearce	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO 218-18-077	17. INFORMANT William Rufenacht		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 62X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			19. INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO Hemorrhage, cavity carcinoma of lung			years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 15, 1966, to Nov. 17, 1966, that (I) (we) last saw the deceased alive on Nov. 17, 1966, and that death occurred of 150 M, from causes and on the date stated above.			
22a. SIGNATURE A.W. Grigoleit		22b. DATE SIGNED 11/17/66	
22c. PHYSICIAN'S NAME (Type) A. W. GRIGOLEIT		22d. ADDRESS Havre de Grace, Harford, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 19, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Mountain Christian Cemetery	23d. LOCATION (City or Town) Joppa
24. FUNERAL DIRECTOR H. Archer, Benson, Md	ADDRESS	25a. RECD BY REGISTRAR NOV 22 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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15729

CERTIFICATE OF DEATH

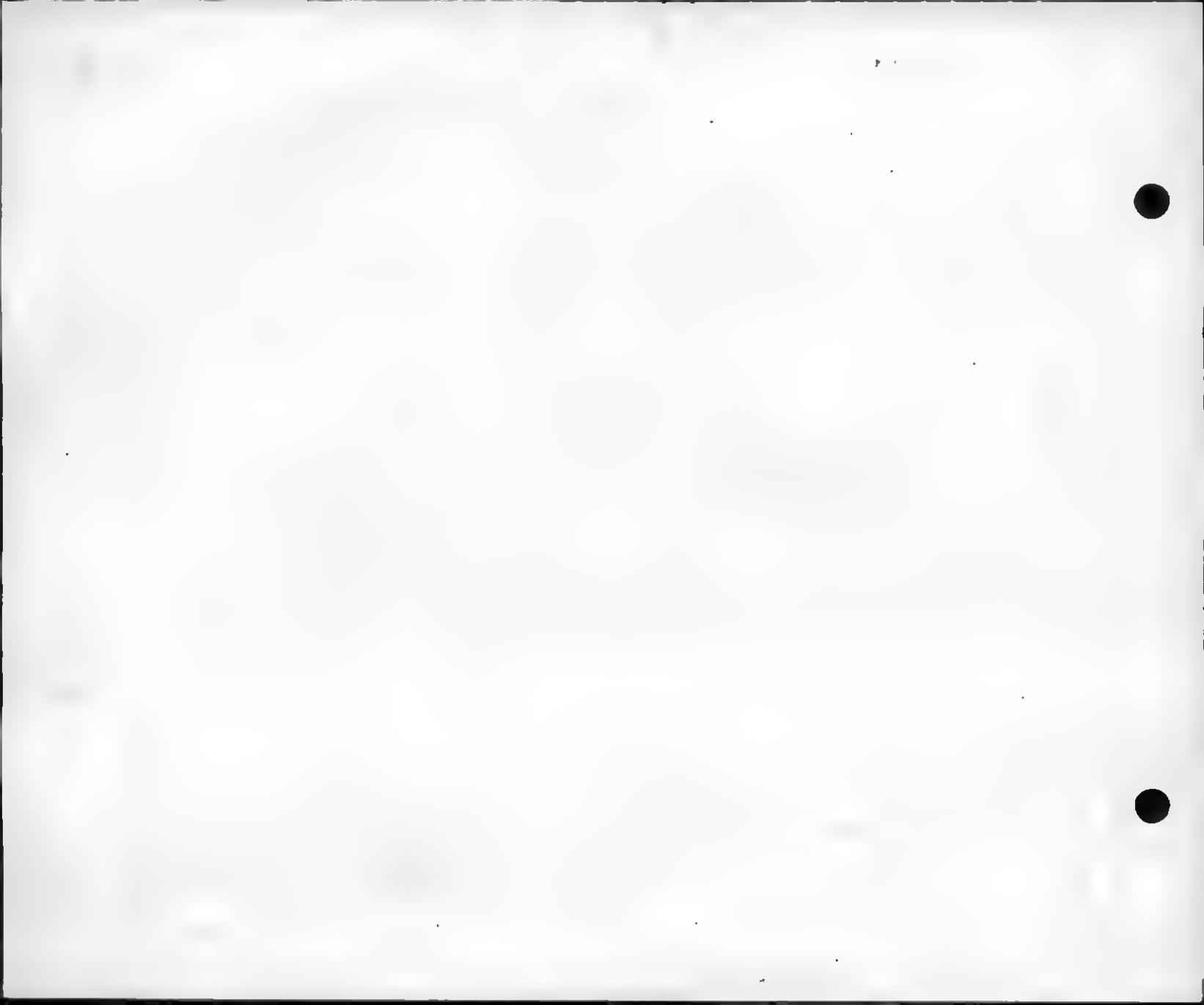
15732

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Harford MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write R. R. # and give nearest town)		b. COUNTY	
Havre-de-Grace 6 days		Harford	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Harford Memorial Hospital		728 South Union Ave	
3 NAME OF DECEASED (Type or print)		4 DATE OF DEATH	
Otis Elmer Snyder		Month	Day
First Middle Last		11	5
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED		8. DATE OF BIRTH	
WIDOWED		Oct 3, 1897	
NEVER MARRIED		9. AGE (In years last birthday)	
DIVORCED		69 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State or foreign country)	
ADMINISTRATIVE ASST. APP. Retired		Pa	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Edward Snyder		Elizabeth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes give war or dates of service)		17. INFORMANT	
		Mr. Elmer T. Snyder - HAVRE DE GRACE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial infarction 3 days	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)			
DUE TO			
lost		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 3, 1966, to Nov 5, 1966, that (I) (we) last saw the deceased alive on Nov 5, 1966, and that death occurred at 9:00 P.M., from causes and on the date stated above.		22b. DATE SIGNED 11/6/66	
22a. SIGNATURE John D. Yun		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS HARFORD, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
31/11		Nov. 3, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State)	
ADDRESS		CATHEDRAL	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
K. Madison Mitchell, Havre-de-Grace, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE NOV 9 1966			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			15733																			
1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY				3. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville				4. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				5. STREET ADDRESS 2017 McHenry St.			6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Samuel Bevard Nursing Home				d. DATE OF DEATH November 27 1966				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. COLOR OR RACE White				8. DATE OF BIRTH July 12, 1893				9. AGE (In years last birthday) 73 yrs.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nursing			10b. KIND OF BUSINESS OR INDUSTRY Hospital				11. BIRTHPLACE (County & State, or foreign country) Norland				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Follieb Sommer				14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212-32-1148				17. INFORMANT Mrs. Anna Kebler, 2017 McHenry, Barks, Md				Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Leukemic leukemia 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 yrs?								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis; chr. arteriosclerotic cardio-vascular disease												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																						
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from Jan. 1964 to Nov. 27, 1966, that (I) (we) last saw the deceased alive on 11-17-66 19, and that death occurred at 9:15 a.m. from the causes and on the date stated above.				22a. SIGNATURE Willard P. Hudson			22b. DATE SIGNED																											
22c. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.				22d. ADDRESS 2323 Rock Spring Road, Forest Hill, Md.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Nov 30 1966			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS New Cathedral Cen			23d. LOCATION (City, town or county) (State) Baltimore City														
24. FUNERAL DIRECTOR Thomas J Kenny, Inc 1570 Volins Balto. Md				25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE DATE NOV 30 1966																										



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M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If day delay is necessary, please execute the certificate, writing the word 'pending', & pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15731

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15734

1 PLACE OF DEATH a COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE					
Hartford MARYLAND		Pa					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b Ephrata					
Rivière de Grâce		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS Hartford Memorial Hospital 5275 State St					
First Richard		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Middle ST 2111		Month November 13 1966					
Last		Day Year					
3 NAME OF DECEASED (Type or print)	4 DATE OF DEATH	Month	Day Year				
M	5 COLOR OR RACE W	6 SEX 7 MARRIED WIDOWED	8 NEVER MARRIED DIVORCED	9 DATE OF BIRTH JUNE 17, 1943	10 AGE (In years last birthday) 23 yrs	11 IF UNDER 1 YEAR Months Days	12 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life even part time) SNOC FACTORY WORKER		10b KIND OF BUSINESS OR INDUSTRY SNOC MFG.		11 BIRTHPLACE (State or foreign country) EPHRATA, Pa		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Jewell Stahl		14 MOTHER'S MAIDEN NAME Caroline Schrantz		Address			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		16 SOC. A. SECURITY NO		17 INFORMANT Mrs. CAROLINE STAHL, EPHRATA, Pa.		18	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture SKULL		DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost		Fracture Pelvis		INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO		(c)					
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a MEDICAL CERTIFICATION PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Auto Accident		20c TIME OF INJURY Month, Day, Year 3:20 pm 11-13-66		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, off ce bldg, etc.) Rte 1		20f (City or town) (County) (State) Conowingo Cecil Md					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Ferdald P Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 11-13-66	
EXAMINER'S NAME (Type) Ferdald P Palmer - MD Address (Street, city, town, or county)							
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE THEREOF 16 Nov. 1966		23c NAME OF CEMETERY OR CREMATORIAL EPERNET		23d LOCATION (City or Town) (County) (State) EPERNET, LANCERON, Pa.	
24 FUNERAL DIRECTOR Name		ADDRESS Patterson, Pa., Homestead, Md.		25a REC'D BY REGISTRAR DATE NOV 15 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

TO DEATH EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 10 to give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PN3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

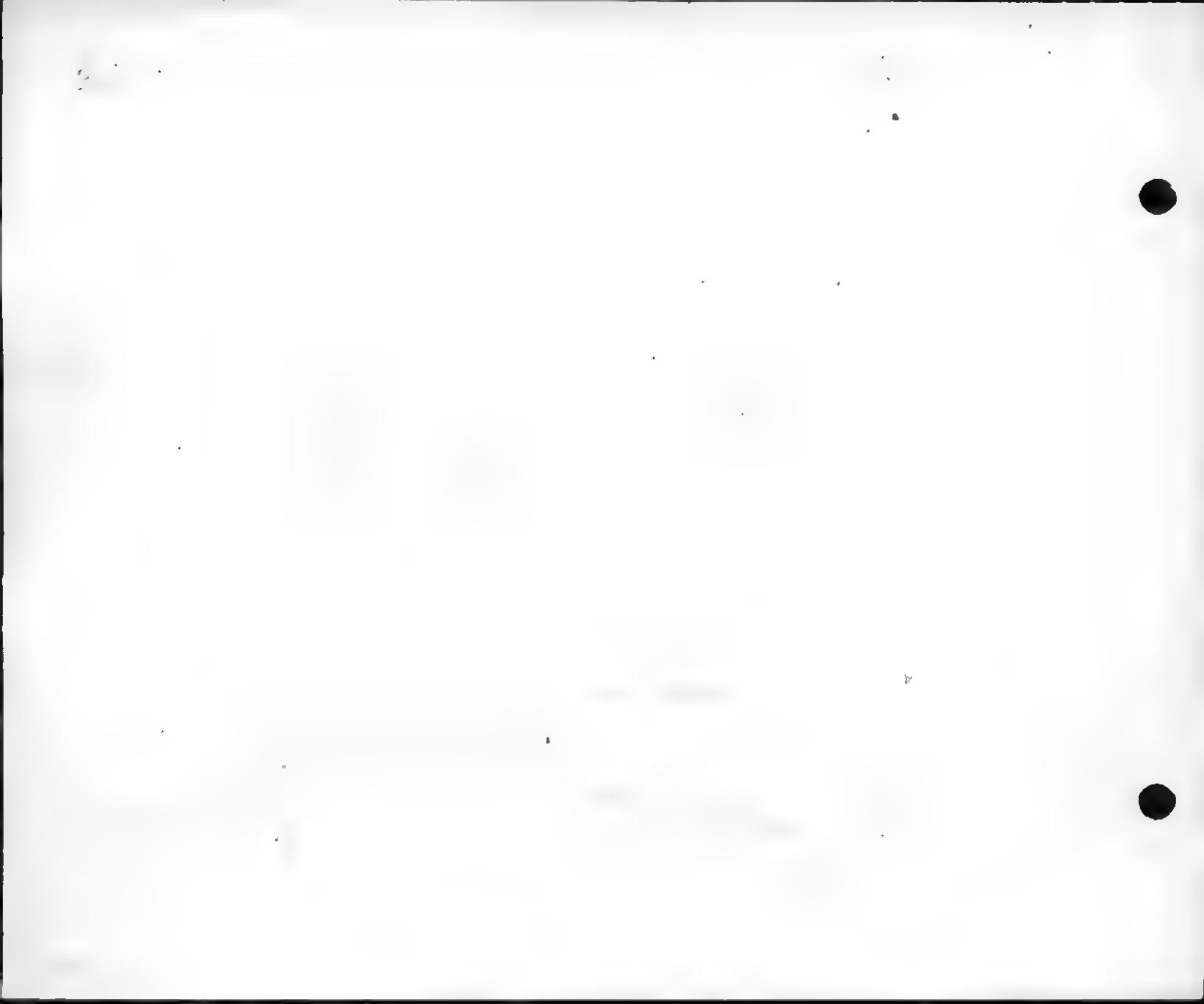
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15732

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15736

1 PLACE OF DEATH a COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE <i>N.Y.</i> b. COUNTY <i>KINGS</i>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Harford Grace</i>		c LENGTH OF STAY IN lb <i>70 min</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>BROOKLYN</i>	
3 NAME OF DECEASED (Type or print) <i>Katherine STRATIS</i>		d STREET ADDRESS <i>1888 Herring ST.</i>	
3 SEX <i>FEMALE</i>	4 COLOR OR RACE <i>White</i>	5 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	6 DATE OF BIRTH <i>FEB 3 1918</i>
7b USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		8 AGE (In years at time of death) <i>48</i>	
10b KIND OF BUSINESS OR INDUSTRY <i>None</i>		9 F UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i>	
11 BIRTHPLACE (State or foreign country) <i>NEW YORK</i>		10c MOTHER'S MAIDEN NAME <i>ATHANASIA HOWES</i>	
12 CITIZEN OF WHAT COUNTRY? <i>USA</i>		13 FATHER'S NAME <i>STEVE STRATIS</i>	
14 INFORMANT <i>DAUGHTER</i>		15 ADDRESS <i>Mrs. MERSINE MERCER, WoodBRIDGE, Va.</i>	
16a CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Fracture skull</i>		16b INTERVAL BETWEEN ONSET AND DEATH	
16c Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ (c) _____		16d DUE TO	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) <i>Autoscooter accident auto-fy 12</i>	
20c TIME OF INJURY Month, Day, Year Hour o.m. <i>Nov 11 1966</i>		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg, etc.) <i>JFK Highway Perryville Hospital</i>
20f (City or town) <i>Perryville Hospital</i>		(County) <i>Carroll</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer M.D.</i>		Address (Street, city, town, or county) <i>Bel Air, Md.</i>	
23a BURIAL, CREMATION REMOVAL (Specify) <i>Burial 11/15/1966</i>		23b DATE THEREOF <i>11/15/1966</i>	
23c NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>CYPRESS</i>		23d LOCATION (City or Town) (County) (State) <i>BROOKLYN NY</i>	
24 FUNERAL DIRECTOR <i>Connington & Son, Harold Deasy, M.D.</i>		25a REC'D BY REG STRAR DATE <i>NOV 15 1966</i>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15733

CERTIFICATE OF DEATH

15735

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Hartford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace, Md 15 miles</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hartford Memorial</i>		d. STREET ADDRESS <i>315 Roberts Way</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Eugene</i>	Middle <i>Gray</i>	Last <i>Stout</i>
4. DATE OF DEATH Month 11	Month 30	Day 19	Year 66
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 Feb 1916
9. AGE (In years from birthday) 50	10. KIND OF BUSINESS OR INDUSTRY <i>Government</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Pa</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Elbert</i>	14. MOTHER'S MAIDEN NAME <i>Maudie Duff</i>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>223-24-1233</i>	17. INFORMANT <i>Peggy Stout, Aberdeen, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Conditions, if any, which gave rise to underlying cause (b), stating the underlying cause last. (c) DUE TO Conditions, if any, which gave rise to underlying cause (c), stating the underlying cause last.		<i>cardiovascular heart disease</i> 10 Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>St. Marys</i>
21. I certify that (I) (this hospital) attended the deceased from <i>July 15</i> , 1966, to <i>Nov 30</i> , 1966, that (I) (we) last saw the deceased alive on <i>Nov 30</i> , 1966, and that death occurred at <i>900 M</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>11-30-66</i>	
22a. SIGNATURE <i>B. J. Plunkett Jr.</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11-30-66</i>
22c. PHYSICIAN'S NAME (Type) <i>B. J. Plunkett Jr.</i>		22d. ADDRESS <i>Aberdeen, Maryland 21001</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE THEREOF <i>5 Dec 66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Tudor Park</i>	23d. LOCATION (City or Town) <i>Baltimore, Md</i>
24. FUNERAL DIRECTOR <i>Walter Ascomby Jr.</i>		25a. ADDRESS <i>Tarring Funeral Home Aberdeen, Md</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		25c. REC'D BY REGISTRAR <i>DEC 2 1966</i>	25d. DATE <i>DEC 2 1966</i>

65501

5/10/1970

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15734

CERTIFICATE OF DEATH

15737

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>HARFORD</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>HARFORD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HARVE DE GRACE</i>	c. LENGTH OF STAY IN 1b <i>16 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	d. STREET ADDRESS <i>R D # 2 Box 165</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>HARFORD Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>AMANDA</i>	First	Middle	Last
4. DATE OF DEATH <i>November 10 1966</i>	Month	Day	Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <i>14 Mar. 1884</i>
9. AGE (In years last birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Smithton, Ill.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>FRANK Yung</i>	14. MOTHER'S MAIDEN NAME <i>CAROLINE Allhouse</i>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	
		<i>Julian F. Ziehnert Bel Air, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO <i>Cardiac Arrest</i> INTERVAL BETWEEN ONSET AND DEATH <i>42 hrs.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Exploratory lap - Cholecystectomy & lymph of adhesions</i> DUE TO <i>586 X</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Bel Air</i> (County) <i>Md.</i> (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>10/26 1966</i> to <i>11/10 1966</i> , that (I) <input type="checkbox"/> last saw the deceased alive on <i>11/10 1966</i> , and that death occurred at <i>9:59 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Charles J. Foley Jr.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11/10/66</i>
22c. PHYSICIAN'S NAME (Type) <i>Charles J. Foley Jr. M.D.</i>		22d. ADDRESS <i>Havre de Grace, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11-12-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Memorial</i>	23d. LOCATION (City or Town) (County) (State) <i>Bel Air, Maryland</i>
24. FUNERAL DIRECTOR <i>John G. Tanning</i>		ADDRESS <i>Tanning Funeral Home</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 14 1966</i>
		A. ADDRESS <i>Aberdeen, Maryland</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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